EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

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<th>Employee Name and Address:</th>
<th>Employer Name and Address:</th>
<th>Insurer Name and Address:</th>
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IMPORTANT: Every employer shall file this report as soon as possible after knowledge of an occupational injury or disease to one of its employees, but no later than ten (10) days thereafter. Failure to file this form shall be subject to civil penalty not to exceed $1,000.

Date and time of Injury: _________________________________________am/pm? Day of the week?________________________________ 
Normal starting time: ____________am/pm? If employee back to work, give date and time: ___________________________________am/pm? 
At what wage? ___________________________ If fatal, give date of death _________________________________ (file supplement report) 
Date/time disability began? _______________________________ am/pm? Was the injured paid in full for this day? _____________________ 
Was the injured given Form No. 7 DCWC? Yes No Foreman/Supervisor________________________________ 
When did you or the foreman first learn of the injury? ____________________________ __________________________ __________________ 
Male   Female   DOB: __________  Employee's Telephone No.: ____________________________________________________________ 
Occupation when injured? _______________________________ Was this his/her regular occupation?__________________ 
(Department or branch regularly employed): _________________________________________________________________ 
Was the injured hired in DC? ________________ How long employed by you? ______________________ _____________________________ 
Piece or time worker? ________________________________ Hourly wage? _____________ Hours worked/day? ______________________ _ 
Daily wages: _________________ Days worked per week: _______________________________ Average weekly earnings:__________________ 
If board and lodging were furnished or gratuities reported in addition to wages, give estimated value per day, week, or month: 
Employer's principal business function in DC: _________________________________________________________________ 
Employer's Telephone No.: ______________________________________ Insurance Policy No.:____________________________________ 
Location of plant or place where accident occurred: ________________________________________________________________________ 
On employer's premises? ____________________________________________________________________________________________ 
Describe fully the events which resulted in injury or disease, what the employee was doing when injured and type of injury including parts of the body affected: ______________________________________________________________________________________________________ 
__________________________________________________________________________________________________________________ 
Name of Witnesses: _________________________________________________________________________________________________ 
Nature and location of injury (Describe fully): ________________________________________________________________________ 
__________________________________________________________________________________________________________________ 
Attending Physician and Address (If Hospital Involved – Indicate): _________________________________________________________________ 
__________________________________________________________________________________________________________________ 
________________________________________________________ 
Name (Please Print or Type) 
_______________________________________________   ________________________________________________________ 
Name of Person Completing Form                  Signature 
________________________________________________________ 
Official Position 
Form No. 8 DCWC 9-2491