WORKER'S COMPENSATION COMMISSION

Department of Labor *Government of Guam
P.O. Box 9970 Tamuning, Guam 96931
Tel: (671) 300-4571/77 Fax: (671) 475-6811

WCC File #:

INSTRUCTIONS: This form maybe used by the Employee when filing a CLAIM for compensation.
CAUTION: 22 GCA 9114 requires the filing of a claim within one (1) year after the date of the injury or date of last payment of compensation to toll the statute of limitation. Third party recovery may be forfeited if a claim is filed.
22 GCA §9132 "Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this Title, or for the purpose of evading liability for any benefit or payment under this Title, shall be guilty of a misdemeanor."

1. Name of injured Employee, DOB & SSN:	2. Name of Employer & EIN No:
3. Employee's Mailing Address & Telephone No: ( )	4. Employer's Mailing Address & Telephone no.: ( )
5. Date & time of alleged injury/illness:	6. Date of Employer's first knowledge of injury:
7. Date & hour Employee first lost time because of injury/illness:	8. Date & hour Employee returned to work:
9. Date & hour pay stopped:	10. Days usually worked per week (mark X days): SUN MON TUES WED THURS FRI SAT Average hours worked per week:
11. Employee's occupation:	12. Employee's wages/earnings (overtime, etc): a. Hourly: $_________ b. Weekly: $
13. Is another person not of your employment the cause of the accident? [ ] YES [ ] NO	14. Will a third party suit be filed? [ ] YES [ ] NO Date filed:

15. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED: Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident.

(Use additional sheets if required and attach to this report)

16. NATURE OF CLAIM FOR COMPENSATION. (EXPLAIN)
a. [ ] Temporary Disability (wages/salary lost)
b. [ ] Permanent Disability (physical lost/loss of use of)
c. [ ] Disfigurement (serious head/facial)
d. [ ] Other

17. Have you received medical attention for this injury? [ ] Yes [ ] No
Give name and address of treating physician/clinic:

18. Name & signature of person completing claim:	19. Date of this claim:

* * * FOR STATISTICAL PURPOSES ONLY * * *

Please choose ONE ETHNICITY:			Please choose ONE CITIZENSHIP:
Yapese	Marshallese	African American	United States
Chuukese	Palauan	Japanese	Permanent Resident Alien
Kosraean	Chamorro	Chinese	Other (specify):
Pohnpeian	Filipino	American	
Korean	Other (specify):		