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 notice is to be filed with the Commissioner when first payment is made. A copy shall be sent to the person to whom compensation is paid. 22 GCA 9115(c). PLEASE PRINT OR TYPE.

1. Name of injured Employee, DOB & SSN:	**2. Name of Employer & ID no:**
3. Employee's mailing address & tel. no: ( )	**4. Employer's mailing address & telephone no.: ( )**
5. Date of alleged injury/illness:	**6. Date disability began:**

7. Weekly rate of compensation to be within minimum/maximum limits established by 22 GCA 9107(b).

Average Weekly Wage (AWW) $ * 0.6666 = $

8. Compensation will be paid from until notice (Form GWC-208) is filed that payment has been stopped or suspended.

9. Beginning date of compensation:	**10. Date of first payment:**

PROCEED TO ITEM 12 IF EMPLOYEE IS NOT DECEASED

11. Person to whom compensation will be paid if injured employee is deceased:

NAME	SSN	RELATIONSHIP	ADDRESS
a.			
b.			
c.			
d.			
e.			

COMPENSATION TO BE CALCULATED AS PROVIDED BY 22 GCA 9109(D) and/or 22 GCA 9110

12. Has medical treatment been provided by physician chosen by injured employee? [ ] Yes [ ] No

13. Name of insurance carrier:

14. Name & Signature of person filing notice:	**15. Date of this notice:**

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):
Pohnepian	Filipino	American	
Korean	Other (specify):		