

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 may be used by the Employer or the Carrier to controvert the right to compensation 22 GCA 9115(d) requires the Employer or the Carrier to PAY compensation PROMPTLY and WITHOUT AWARD unless the right to compensation is controverted by the filing of this notice. Failure to either pay each compensation installment, or controvert the right to compensation, within fourteen (14) days after it becomes due, may result in liability for additional compensation equal to 10% of each installment not paid when due. If the right to compensation is controverted, reasons for controversion should be fully stated in Item 8. Complete and send original to the Worker's Compensation Commission and a copy to the Employee.		
1. Name of injured Employee:	2. Name of Employer & EIN/ID No:	
3. Employee's mailing address & telephone no: ()	4. Employer's mailing address & telephone no.: ()	
5. Date of alleged injury/illness:	6. Date of Employer/Carrier's knowledge of injury:	
7. Nature of alleged injury/illness:		
8. NOTICE IS GIVEN that the following are being respectively controverted:		
	a. Temporary Disability during:	8f. Reason(s):
	b. Permanent Disability	
	c. Medicals	
	d. Death	
	e. Others:	
9. Do you believe the controversy can be SETTLED by an informal conference? YES/NO		
11. Date copy of this notice PROVIDED to Claimant or representative:		12. Name of Carrier:
13. Date of this notice:		14. Name of person filing this notice:
15. Title of person filing this notice:		16. Signature of person filing this notice:
*** FOR STATISTICAL PURPOSES ONLY ***		
Please choose one ETHNICITY:		Please choose one CITIZENSHIP:
Yapese Marshallese Filipino	United States	
Chuukese Palauan American	Permanent Alien Resident	
Pohnpeian Chamorro African American	Other (specify):	
Chinese Korean Other (specify):		