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 report must be filed promptly with the Commissioner in every case in which (1) Form GWC-202 does not show the date employee returned to work, and (2) each time an injured employee has returned to work but later becomes disabled for work. If the employee is medically certified disabled for work, compensation payments should be reported on Forms GWC-206 and/or GWC-208. Medical reports must be sent to the Commissioner promptly following first treatment and thereafter while treatment continues.

1. Employee's name, mailing address, DOB, & SSN: - - Home phone: ( ) Work phone: ( )	2. Name and address of your insurance carrier:

3. Date of initial injury/illness:	4. Date of initial disability:	5. Date of initial return to work:

6. Is Employee receiving pre-injury wages? [ ] YES [ ] NO	7. Employee's pre-injury regular wages:

8. If this report covers a period of disability after the date shown in Item 5, state each subsequent period of disability. Use inclusive dates for (a) and (b).

(a) From	(b) To	(c) Date of return to work	(d) Wages received

9. Did Employee receive medical attention?

[ ] YES - List dates, names and addresses of physicians and hospitals providing treatments.
[ ] NO - Explain.

10. Name address of Employer:	11. Date insurance carrier provided copy of report:
	12. Name and signature of person making report:
	13. Title of person making report:
	14. Date of this report:

*** * * FOR STATISTICAL PURPOSES ONLY * * ***

Please choose one ETHNICITY:			Please choose one CITIZENSHIP:
Yapese	American	Chamorro	United States
Chuukes	African American	Filipino	Permanent Resident Alien
Kosraean	Korean	Chinese	Other (specify):
Pohnpeian	Other (specify):		