WORKER'S COMPENSATION COMMISSION (WCC)

Guam Department of Labor
P.O. Box 9970 • Tamuning, Guam 96931
Email Address: *wcc@dol.guam.gov*
Tel: (671) 300-4571/77 • Fax: (671) 475-6811

EMPLOYER (PUBLIC)
WHAT TO DO IN CASE OF A WORK INJURY

1. **PREPARE MEDICAL AUTHORIZATION**. Form **GWC-101A/B** (Authorization for Medical Examination and/or Treatment), should accompany the injured person to the clinic when obtaining initial medical treatment unless it is an emergency situation. This form must be **FULLY COMPLETED** to ensure billing is correctly routed. Issue **ONLY** the initial (first) authorization. WCC will then be responsible for **all** subsequent authorizations (includes prescriptions) thereafter if required.

   GOVGUAM EMPLOYEES: **are to be sent to the GUAM MEMORIAL HOSPITAL for the initial medical treatment pursuant to 17 GAR Div. 2, Chap. 10, 10107(b) unless otherwise authorized by WCC. Any referrals after this initial treatment must be authorized by WCC.**

   PLEASE ADVISE EMPLOYEE TO GO DIRECTLY TO WCC AFTER CHECKING OUT OF GMH.

   Please instruct the injured employee NOT to utilize his/her personal health insurance when obtaining medical care for the work injury nor to pay any of the charges incurred.

   IMPORTANT: If employee obtains medical treatment without first requesting from the employer or WCC, employee may not be reimbursed for any out-of-pocket medical expenses, unless employee was refused such authorization by employer. 22 GCA §9108

2. **PROVIDE THE EMPLOYEE WITH FORM GWC-201** (Notice of Employee's Injury/Illness or Death) or you may use your own incident report forms.

3. **COMPLETE FORM GWC-202** (Employer's Report of Occupational Injury or Illness) and file with our office **within TEN (10) calendar days** from the date of the accident or when you first became aware of the injury. The date employer obtained knowledge of the accident/injury will be "day one (1)". **Failure** to file this report in a timely manner may subject your company/agency to penalties amounting to $500.00 for **each** failure or refusal to file such report.

4. ***IMPORTANT:*** *A copy of these reports along with any and all medical documents received from the employee* ***MUST*** *be provided to* ***WCC*** *so as to properly facilitate the claim.*

WARNING: Misrepresentation of facts in order to obtain or evade liability of worker's compensation benefits shall be guilty of a misdemeanor.

Revised 10/26/2015

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WCC File#

INSTRUCTIONS: This side of the form should be completed in full. It authorizes a physician (duly qualified physicians include surgeons, osteopathic acupuncturists within the scope of their practice as defined by law) to examine and/or treat the employee for the injuries arising out of such accidental occupational injury, illness, or disease covered by the Guam Worker's Compensation Law. PLEASE TYPE OR PRINT LEGIBLY.

1. Name of Authorized Physician:	2. Name of Medical Facility:
Physician on Duty at GMHA	Guam Memorial Hospital Authority
3. Physician's Address:	**4. Medical Facility's Address:**
Same as box 4	850 Gov Carlos Camacho Road Tamuning, Guam 96911

5. Name of Injured Employee , DoB, & SSN:	6. Occupation:	7. Date of Injury:

8. Description of Injury:

9. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS: (Please check one)

☐	**A) If you believe the condition is related to the injury, furnish office and/or hospital treatment as necessary for the effects of the injury.**
☐	**B) If there is doubt as to whether the condition is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in Item 14 whether you believe the disability is due to the alleged injury. Pending further advice, you may provide such necessary conservative treatment.**
xxxxxxxxxxxxx	**C) Other: EXAMINATION & TREATMENT of INJURY(IES) AS STATED IN BOX 8 – SINGLE VISIT ONLY. ****** AUTHORIZATION INVALID IF ALTERED WITHOUT PRIOR APPROVAL BY WCC OFFICE **************************

YOU ARE REQUESTED TO SUBMIT A WRITTEN REPORT OF FIRST TREATMENT WITHIN 20 DAYS TO THE COMMISSIONER AT THE ADDRESS INDICATED ITEM 13 BELOW. (See back of this form for instructions as to the medical report and the submission of your charges). Reports are requisite if services are to be paid.

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."

10. Signature and Title of Authorizing Official:	11. Name and Address of Employer:
12. Date:	

13. Send your REPORT to:	14. Name & address of Insurance Carrier to whom COPY of your report and BILL are to be sent:
WORKER'S COMPENSATION COMMISSION P.O. Box 9970 Tamuning, Guam 96931	**See Box 13**

FOR STATISTICAL PURPOSES ONLY:

Employee's ethnicity (please choose one):	*Employee's citizenship (please choose one):*
Yapese Pohnpeian American Korean Chuukese Marshalls Pacific Islander Chinese Kosraean Palauan Filipino Japanese Other (specify):	*U.S. Permanent Alien Resident Other (specify):*

ATTENDING PHYSICIAN'S REPORT OF INJURY AND TREATMENT

INSTRUCTIONS TO PHYSICIAN: This initial report should be completed and mailed within 20 days, the original to the Commissioner (see item 13 for address), with a copy to the Company in item 14. Subsequent reports should be made regularly on Form GWC-204 or in narrative form while employee is in your care. Please read Item 9 on the front of this form. PLEASE TYPE OR PRINT LEGIBLY.

15. What history of injury or disease did Employee give to you?

16. Is there any history or evidence of PRE-EXISTING injury, disease, or physical impairment? [ ] NO [ ] YES (Describe):

17. What are your findings?	**18. What is your diagnosis?**

19. Do you believe the condition found was CAUSED or AGGRAVATED by the employment activity described? [ ] YES [ ] NO
(Please explain if there is doubt):

20. Did injury require hospitalization? [ ] YES [ ] NO **Hospital:** **Admission date:** **Discharge date:**	**21. Is additional hospitalization required? [ ] YES [ ] NO**

22. Surgery (If any, please describe):

Date performed:

23. Other types of treatments:	**24. What PERMANENT DEFECTS do you anticipate?**

25. Date of first examination:	**26. Dates of treatments:**	**27. Date of discharge:**

28. Period of TEMPORARY DISABILITY **(Indicate if unknown):** **Partial Disability: From To** **Total Disability: From To**	**29. Date Employee was able to resume work:** **LIGHT WORK [ ]** **REGULAR WORK [ ]**

30. If Employee is able to resume work, date when advised:

31. If Employee is able to resume only light work, indicate extent of PHYSICAL LIMITATIONS and type of work he could reasonably perform with limitations:

32. General remarks and RECOMMENDATIONS for future care, if indicated:

33. Do you SPECIALIZE? [ ] NO [ ] YES (Please specify):

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34. Name & Signature of Physician:	**35. Address:**
36. Date of report:	

37. MEDICAL BILL (Charges for your services may be presented in the space below or on your billhead).

Date/Period of treatment(s)	Service/Supplies (MUST be itemized)	Quantity	Unit Price	Amount

Form GWC-101b Revised (3/2014)

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Tel: (671) 300-4571/77 Fax: 671-475-6811

WCC File #:

INSTRUCTIONS: This form may be used by the Employee to file a NOTICE of an injury, illness or in the case of death, by Employee's representative. No benefits need be paid without this notice. Notice shall be given to the Commissioner and to the Employer by delivery or to the last known place of business. 22 GCA 9113. **PLEASE PRINT OR TYPE.**

**** THIS IS NOT A CLAIM ****

1. Name of injured Employee, DOB, & SSN: - -	2. Name of Employer & EIN:
3. Employee's address & telephone no: ( )	4. Employer's address:
5. Date & time of alleged injury/illness:	6. Did employee stop work? If so, date stopped:
7. Employee's occupation:	8. Name of supervisor at time of injury:
9. Place where injury occurred:	
10. Is another person not of your employment the cause of the accident? [ ] YES [ ] NO	11. Will you file suit against the other person? [ ] YES [ ] NO
12. 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 object or substance 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.	
13. Effects of the injury (Indicate parts of body affected and how affected).	

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14. Name & signature of person completing this notice:	15. Date of this notice:

FOR STATISTICAL PURPOSES ONLY

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

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WCC File #:

INSTRUCTIONS: This form may be used by the Employer to report an injury or illness. 22 GCA 9131 requires the Employer to report to the Commissioner within ten (10) days from the date of or knowledge of any injury or illness. Failure or refusal to file this report may subject the Employer to a penalty of up to $500.00. **PLEASE PRINT OR TYPE.**

1. Name of injured Employee, DOB & SSN:	2. Name of Employer & EIN:
3. Employee's address & telephone no: ( )	4. Employer's 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 (x days): S M T W TH F S Average hours per week: ☐☐☐☐☐☐☐
11. Employee's occupation:	12. Employee's wages/earnings (overtime, etc):
13. Is another person not of your employment caused the accident? [ ] YES [ ] NO	a. Hourly: $ b. Weekly: $

14. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED: Relate the events which resulted in the injury/illness. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance 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.

15. NATURE OF INJURY/ILLNESS (Name part of body affected - fractured leg, bruised arm, lacerated finger, etc) Note any amputations.

16. Has medical attention been authorized? [ ] YES [ ] NO	17. Date authorized:	18. Has insurance carrier been notified? [ ] YES [ ] NO	19. Date notified:
20. Name of treating physician:		21. Name of insurance carrier: **Worker's Compensation Commission c/o Guam Dept of Labor**	
22. Name of treating facility:		23. Name & signature of person completing report:	

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24. Title of person completing report:	25. Date of this report:

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):		

PLEASE CIRCLE THE APPROPRIATE ITEMS (for statistical purposes)

A. EVENT CODE

01 Fatality	02 No Time Loss	03 Time Loss

B. NATURE OF INJURY CODE

01 Amputation	08 Disease/Illness	15 Hearing Loss
02 Asphyxia	09 Dislocation	16 Hernia
03 Bruise/Contusion/Abrasion	10 Electric Shock	17 Poisoning (Systemic)
04 Burn (Chemical)	11 Exertion	18 Puncture
05 Burn (Heat)	12 Foreign Body in Eye/Conjunctivitis	19 Radiation Effects
06 Concussion	13 Fracture	20 Strain/Sprain
07 Cut/Laceration/Puncture	14 Freezing/Frostbite	21 Other (Specify)

C. BODY PART CODE LEFT | RIGHT

Abdomen	01		Thumb	14	15	Great Toe	34	35
Ankle(s):	02	03	Fingers Index-Small			Toes		
Back	04		(First-Fourth)	16 17 18	20 21 22	(First-Fourth)	36 37 38 39	40 41 42 43
Body	05			19	23			
System	06		Wrist			Ankle	44	45
Chest	07		Hand	24	25	Foot	46	47
Head	08		Elbow	26	27	Knee	48	49
Ear(s)	09	10	Arm	28	29	Leg	50	51
Eye(s)	11	12	Shoulder	30	31	Hip(s)	52	53
Face	13			32	33			

D. TYPE OF EVENT CODE

01 Absorption	05 Fall (Same level)	10 Rubbed/Abraded
02 Bite/Sting/Scratch	06 Fall (From elevation)	11 Shock
03 Cardio-Vascular/Respiratory System Failure	07 Ingestion	12 Struck Against
	08 Inhalation	13 Struck By
04 Caught In or Between	09 Repeated Motion/Pressure	14 Other (Specify)

E. SOURCE INJURY CODE

01 Aircraft	15 Electrical Apparatus/Wiring	29 Metal Products
02 Air Pressure	16 Explosives	30 Motor Vehicle (Highway)
03 Animal/Insect/Bird/Reptile/Fish	17 Fire/Smoke	31 Motor Vehicle (Industrial)
04 Boat	18 Food	32 Motorcycle
05 Bodily Motion	19 Furniture/Furnishings	33 Person
06 Boiler/Pressure Vessel	20 Gases	34 Petroleum Products
07 Boxes/Barrels, Etc.	21 Glass	35 Pump/Prime Motor
08 Buildings/Structures	22 Hand Tool (Manual)	36 Radiation
09 Chemical Liquid/Vapor	23 Hand Tool (Powered)	37 Vegetation
10 Cleaning Compound	24 Heat (Environmental/Mechanical)	38 Waste Products
11 Cold (Environment/Mechanical)	25 Hoisting Apparatus	29 Water
12 Dirt/Sand/Stone	26 Ladder	40 Weapons
13 Drugs/Alcohol	27 Machine	41 Working Surface
14 Dust/Particles/Chips	28 Materials Handling Equipment	42 Other (Specify)

F. CONTRIBUTING ENVIRONMENTAL FACTOR CODE

01 Catch Point/Pointer Action	10 Pinch Point Action
02 Chemical Action/Reaction Exposure	11 Radiation Condition
03 Flammable Liquid/Solid Exposure	12 Shear Point Action
04 Flying Object Motion	13 Sound Level
05 Gas/Vapor/Mist/Fume/Smoke/Dust Condition	14 Squeeze Point Action
06 Illumination	15 Temperature Above or Below Tolerance Level
07 Materials Handling Equipment/Method	16 Weather/Earthquake, Etc. Condition
08 Overhead Moving and/or Falling Object Action	17 Working Surface/Facility Layout Condition
09 Overpressure/Underpressure Condition	18 Other (Specify)

G. TASK ASSIGNMENT CODE

01 Employee Working at Regularly Assigned Task(s)	02 Employee Working at OTHER than Regularly Assigned Task(s)