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

EMPLOYEE (PRIVATE)
WHAT TO DO IN CASE OF A WORK INJURY

1. **REPORT** the accident immediately to your employer regardless of whether or not you need medical treatment. Request form **GWC-201** (Notice of Employee's Injury/Illness or Death) from your employer. Complete form. Sign the form. Provide copy to your employer. Make sure you retain an acknowledged copy of your report. You **MUST** report your injuries **IMMEDIATELY**. Your employer will provide forms GWC-201, GWC-202, and GWC-101A/B to your insurance adjuster.

   If you need immediate medical treatment, obtain form **GWC-101A/B** (Authorization for Medical Examination and/or Medical Treatment) from your employer. Your employer will issue **only** the first (initial) authorization. **All other (subsequent) authorizations shall be issued by the employer's worker's compensation insurance carrier. Unless it is an emergency situation, this form is to accompany you to the clinic. DO NOT USE YOUR PERSONAL HEALTH INSURANCE and DO NOT PAY FOR ANY MEDICAL SERVICES YOU RECEIVED.**

> **IMPORTANT:** If you obtain medical treatment without first requesting from your supervisor/employer or your employer's compensation insurance company, you may not be reimbursed for any out-of-pocket medical expenses, unless you have been refused such authorization by your employer. 22 GCA §9108

You **SHOULD** always obtain or request for authorization before receiving any medical treatment unless your injuries are such that emergency care is required.

2. Copies of forms GWC-201, GWC-202, and GWC 101A/B must be provided to WCC within 10 days from date of injury.

3. If **ANOTHER PERSON**, who is neither a co-employee nor your employer, is the cause of the accident in which you sustained injuries you **MUST** file form **GWC-203** (Employee's Claim for Compensation) even if you decide to file **SUIT** or recover against the other person or persons. Should you win your suit, your employer's worker's comp insurance carrier can subrogate against any settlement you received for worker's comp benefits that were paid out to you.

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

Revised 8/9/2017 *All forms mentioned may be obtained from employer, insurance carrier, or WCC.

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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).	

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."

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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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:	
3. Physician's Address:	4. Medical Facility's Address:	
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.**
☐	**C) Other:**

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 <u>are requisite</u> if services are to be paid.

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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

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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):**		

Form GWC-203: EMPLOYEE'S CLAIM for COMPENSATION (Rev 1/2014)