



## WORKER'S COMPENSATION COMMISSION (WCC)

Guam Department of Labor

P.O. Box 9970 • Tamuning, Guam 96931

Email Address: [wcc@dol.guam.gov](mailto:wcc@dol.guam.gov)

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

### EMPLOYER (PRIVATE)

### 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. Your carrier will then be responsible for all subsequent authorizations thereafter if required.**

**IMPORTANT:** *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.*

Instruct your employee to go to carrier for any authorizations after their initial visit with their doctor or hospital.

2. **PROVIDE THE EMPLOYEE WITH FORM GWC-201** (Notice of Employee's Injury/Illness or Death - must be signed by the Employee) and you may also attached your Company's incident report forms to GWC-201.
3. **COMPLETE FORM GWC-202** (Employer's Report of Occupational Injury or Illness) and file with the Worker's Compensation Commission (WCC) **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.

**IMPORTANT:** *A copy of these reports along with any and all medical documents received from the employee **MUST** be provided to your **WORKER'S COMPENSATION INSURANCE CARRIER and this office** 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 12/4/2015 Employers will provide the necessary forms to the employee.

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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:	
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 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:  <b>WORKER'S COMPENSATION COMMISSION P.O. Box 9970 Tamuning, Guam 96931</b>	14. Name & address of Insurance Carrier to whom COPY of your report and BILL are to be sent:  <p align="center">See Box 13</p>
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**FOR STATISTICAL PURPOSES ONLY:**

<b>Employee's ethnicity (please choose one):</b>	<b>Employee's citizenship (please choose one):</b>																								
<table style="width:100%; border: none;"> <tr> <td><i>Yapese</i></td> <td><i>Pohnpeian</i></td> <td><i>American</i></td> </tr> <tr> <td><i>Korean</i></td> <td></td> <td></td> </tr> <tr> <td><i>Chuukese</i></td> <td><i>Marshalls</i></td> <td><i>Pacific Islander</i></td> </tr> <tr> <td><i>Chinese</i></td> <td></td> <td></td> </tr> <tr> <td><i>Kosraean</i></td> <td><i>Palauan</i></td> <td><i>Filipino</i></td> </tr> <tr> <td><i>Japanese</i></td> <td></td> <td></td> </tr> <tr> <td colspan="3"><i>Other (specify):</i></td> </tr> </table>	<i>Yapese</i>	<i>Pohnpeian</i>	<i>American</i>	<i>Korean</i>			<i>Chuukese</i>	<i>Marshalls</i>	<i>Pacific Islander</i>	<i>Chinese</i>			<i>Kosraean</i>	<i>Palauan</i>	<i>Filipino</i>	<i>Japanese</i>			<i>Other (specify):</i>			<table style="width:100%; border: none;"> <tr> <td><i>U.S.</i></td> </tr> <tr> <td><i>Permanent Alien Resident</i></td> </tr> <tr> <td><i>Other (specify):</i></td> </tr> </table>	<i>U.S.</i>	<i>Permanent Alien Resident</i>	<i>Other (specify):</i>
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## 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):

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."

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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## 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 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.**

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? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. Will you file suit against the other person? <input type="checkbox"/> YES <input type="checkbox"/> 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).			
<b>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."</b>			
14. Name & signature of person completing this notice:		15. Date of this notice:	
<b>FOR STATISTICAL PURPOSES ONLY</b>			
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):		



**PLEASE CIRCLE THE APPROPRIATE ITEMS (for statistical purposes)**

**A. EVENT CODE**

01 Fatality	02 No Time Loss	03 Time Loss
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**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 (First-Fourth)	16 17 18	20 21 22	Toes (First-Fourth)	36 37 38 39	40 41 42 43
Back	04			19	23			
Body System	05		Wrist			Ankle	44	45
Chest	06		Hand	24	25	Foot	46	47
Head	07		Elbow	26	27	Knee	48	49
Ear(s)	08	10	Arm	28	29	Leg	50	51
Eye(s)	09	12	Shoulder	30	31	Hip(s)	52	53
Face	11			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
04 Caught In or Between	08 Inhalation	13 Struck By
	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	39 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/Under pressure 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)
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