



WORKER'S COMPENSATION COMMISSION (WCC)

Guam Department of Labor

P.O. Box 9970 • Tamuning, Guam 96931

Email Address:

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 GMHA or GRMC for the initial medical treatment pursuant to 22 GCA 9108(e). Any referrals after this initial treatment must be authorized by WCC.

PLEASE ADVISE EMPLOYEE TO GO DIRECTLY TO WCC AFTER CHECKING OUT OF GMHA or GRMC.

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(a)

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.

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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: Physician on Duty at GMHA		2. Name of Medical Facility: Guam Memorial Hospital Authority	
3. Physician's Address: Same as box 4		4. Medical Facility's Address: 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)

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

Employee's ethnicity (please choose one):				Employee's citizenship (please choose one):	
Yapese	Pohnpeian	American	Korean	U.S.	
Chuukese	Marshalls	Pacific Islander	Chinese	Permanent Alien Resident	
Kosraean	Palauan	Filipino	Japanese	Other (specify):	
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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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? <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).	
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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 Chuukese Palauan African American Kosraean Guamanian Japanese Pohnpeian Filipino Korean Chinese Other (specify):	United States Permanent Resident Alien 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 (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				
	13								
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				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)				