WORKER'S COMPENSATION COMMISSION

Department of Labor
P.O. Box 9970
Tamuning, Guam 96931
Tel: (671) 475-7033/34 *Fax: (671) 475-7045

EMPLOYER
WHAT TO DO IN CASE OF A WORK INJURY

1. **PREPARE MEDICAL AUTHORIZATION.** Form **GWC-101a/b** (Authorization to receive medical care), should accompany the injured person to the clinic when obtaining medical treatment. This form must be **FULLY COMPLETED** to ensure billing is correctly routed.

   IMPORTANT: Instruct the injured employee **NOT** to utilize his / her personal heatlh insurance when obtaining medical care for the work injury.

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. Providing employee with an informative pamphlet explaining the benefits under the Worker's Compensation Law would be helpful.

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 on Form GWC-201 (employee's report) may be used as day one (1). Failure to file this report in a timely manner may subject your company to penalties ($500.00 for each failure or refusal).

4. **SUPPLEMENTARY REPORT.** Once the employee has returned to work and if the date of the employee's return to work in NOT indicated in your GWC-202 report, complete for GWC-210 (Employer's supplementary report of injury /illness) for **EACH** day / period employee losses time from work because of his / her work injury.

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 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.

WORKER'S COMPENSATION COMMISSION

Department of Labor
Government of Guam

Tel: (671) 675-7033 or 7034 * Fax: (671) 675-7045

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
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. Daily: $______ c. Weekly: $______ d. Yearly: $______

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 authorize: [ ] 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:
22. Name of treating facility:	23. Name & signature of person completing report:

22 GCA 9132 PENALTY FOR MISREPRESENTATION: "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 and on conviction thereof shall be punished by a fine not to exceed one thousand dollars ($1,000.00), or by imprisonment not to exceed one (1) year, or both."

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

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

	LEFT	RIGHT		LEFT	RIGHT		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	40 41 42
Body	05			19	23		39	43
System	06		Wrist			Ankle		
Chest	07		Hand	24	25	Foot	44	45
Head	08		Elbow	26	27	Knee	46	47
Ear(s)	09	10	Arm	28	29	Leg	48	49
Eye(s)	11	12	Shoulder	30	31	Hip(s)	50	51
Face	13			32	33		52	53

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 Over pressure/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)

WORKER'S COMPENSATION COMMISSION

Department of Labor
Government of Guam
P.O. BOX 9970, TAMUNNING GUAM 96931
Tel: (671) 475-7033/34 * Fax: (671) 675-7026

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: NA**
7. Employee's occupation:	**8. Name of supervisor a 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 PENALTY FOR MISREPRESENTATION: "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 and on conviction thereof shall be punished by a fine not to exceed one thousand dollars ($1,000.00), or by imprisonment not to exceed one (1) year, or both."

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

WORKER'S COMPENSATION COMMISSION

Department of Labor
Government of Guam
P.O. BOX 9970 TAMUNING GUAM 96931
Tel: (671) 475-7033/34*Fax: (671) 475-7045

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:

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.

GCG 37031 PENALTY FOR MISREPRESENTATION: "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 and on conviction thereof shall be punished by a fine not to exceed one thousand dollars ($1,000.00), or by imprisonment not to exceed one (1) year, or both."

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:
SAME AS #14	C/O EQUITABLE ADJUSTING & SERVICE CO. Suite 217 JULALE CENTER, 424 WEST O'BRIEN DR. HAGATNA GUAM 96910

FORM GWC-101a: AUTHORIZATION for MEDICAL EXAMINATION and/or TREATMENT (Revised 12/95)

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)*:

GCG 37031 PENALTY FOR MISREPRESENTATION: "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 a[nd] on conviction thereof shall be punished by a fine not to exceed one thousand dollars ($1,000.00), or by imprisonment not to exceed one (1) year, or both."

34. Name & Signature of Physician:

35. Address:

36. Date of report:

Form GWC-101b rev 9/98

WORKER'S COMPENSATION COMMISSION

Department of Labor *Government of Guam
P.O. Box 9970 Tamuning, Guam 96931
Tel: (671) 475-7033/34 Fax: (671) 475-7026

WCC File #:

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 09/2008)

WORKER'S COMPENSATION COMMISSION

Department of Labor
Government of Guam
P.O. BOX 9970
TAMUNING GUSM 96931
Tel: (671) 675-7033 or 7045 *Fax: (671) 675-7045

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:

Form GWC-210: EMPLOYER'S SUPPLEMENTARY REPORT of ACCIDENT or OCCUPATIONAL ILLNESS (Rev 9/98)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File #:

INSTRUCTIONS: This notice is to be filed with the Commissioner when first payment is made. A copy shall be sent to the person to whom compensation is paid. 22 GCA 9115(c). PLEASE PRINT OR TYPE.

1. Name of injured Employee, DOB & SSN:	2. Name of Employer & ID no:
3. Employee's mailing address & tel. no: ( )	4. Employer's mailing address & telephone no.: ( )
5. Date of alleged injury/illness:	6. Date disability began:

7. Weekly rate of compensation to be within minimum/maximum limits established by 22 GCA 9107(b).

Average Weekly Wage (AWW) $ * 0.6666 = $

8. Compensation will be paid from until notice (Form GWC-208) is filed that payment has been stopped or suspended.

9. Beginning date of compensation:	10. Date of first payment:

PROCEED TO ITEM 12 IF EMPLOYEE IS NOT DECEASED

11. Person to whom compensation will be paid if injured employee is deceased:

NAME	SSN	RELATIONSHIP	ADDRESS
a.			
b.			
c.			
d.			
e.			

COMPENSATION TO BE CALCULATED AS PROVIDED BY 22 GCA 9109(D) and/or 22 GCA 9110

12. Has medical treatment been provided by physician chosen by injured employee? [ ] Yes [ ] No

13. Name of insurance carrier:

14. Name & Signature of person filing notice:	15. Date of this notice:

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):		

Form GWC-206: NOTICE to COMMISSIONER that PAYMENT of COMPENSATION begun WITHOUT AWARD (Rev 12/04)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File#: 2007-000946

INSTRUCTIONS: This form may be used by the Employer or the Carrier to controvert the right to compensation 22 GCA 9115(d) requires the Employer or the Carrier to PAY compensation PROMPTLY and WITHOUT AWARD unless the right to compensation is controverted by the filing of this notice. Failure to either pay each compensation installment, or controvert the right to compensation, within fourteen (14) days after it becomes due, may result in liability for additional compensation equal to 10% of each installment not paid when due. If the right to compensation is controverted, reasons for controversion should be fully stated in Item 8. Complete and send original to the Worker's Compensation Commission and a copy to the Employee.

1. Name of injured Employee:	2. Name of Employer & EIN/ID No:
3. Employee's mailing address & telephone no: ( )	4. Employer's mailing address & telephone no.: ( )
5. Date of alleged injury/illness: 03/17/07	6. Date of Employer/Carrier's knowledge of injury:

7. Nature of alleged injury/illness:

EMPLOYEE HEARD A POP TO HIS KNEE WHILE PARTICIPATING IN SUSPECT APPREHENSION TRAINING EXERCISE. PAIN AND SWELLING TO RIGHT KNEE.

8. NOTICE IS GIVEN that the following are being respectively controverted:

		8f. Reason(s):
	a. Temporary Disability during:	
	b. Permanent Disability	
	c. Medicals	
	d. Death	
	e. Others:	

9. Do you believe the controversy can be SETTLED by an informal conference? YES/NO	10. Do you want to petition for a FORMAL HEARING? (Answer required) YES/NO
11. Date copy of this notice PROVIDED to Claimant or representative:	12. Name of Carrier:
13. Date of this notice:	14. Name of person filing this notice:
15. Title of person filing this notice:	16. Signature of person filing this notice:

*** FOR STATISTICAL PURPOSES ONLY ***

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

FORM GWC-207: NOTICE to COMMISSIONER of CONTROVERSION of RIGHT to COMPENSATION (Rev Jan 2005)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 Tamuning Guam 96931
Tel: (671) 475-7033/34 * Fax: (671475-7026

WCC File #:

INSTRUCTIONS: This notice MUST be filed with the Commissioner within 16 days after compensation has either been suspended or terminated. If payments have been suspended but will be reinstated or are being modified, indicate on Item 11 and the reasons therefore. This form is to be used in reporting either disability or death payments.
PENALTY FOR LATE OR NON-FILING: Delay in or failure to file this notice as required by the Worker's Compensation Commission shall subject payor to a penalty of $100. 22 GCA 9115(q). PLEASE PRINT OR TYPE.

1. Name of injured Employee, DOB, & SSN: - -
2. Name of Employer & EIN:
3. Employee's mailing address:
4. Employer's mailing address & telephone no.:
5. Date of injury/illness:
6. Date Employee first lost time:
7. Date Employee first lost pay:
8. Date Employee medically able to return to work:
9. Date Employee returned to work:
10. AVERAGE WEEKLY WAGE (AWW) * 0.6666 = (WEEKLY COMPENSATION RATE)
11. State reason for suspension or termination of compensation:
12. ENTER ALL DISABILITY PAYMENTS (22 GCA 9109)

TYPE OF DISABILITY	FROM	TO	AMT PAID PER WEEK	# OF WEEKS PAID	TOTAL
Temporary Total					
Temporary Partial					
Permanent Total					
Permanent Partial	%	Part of Body			

13. ENTER ALL DEATH COMPENSATION (22 GCA 9110)

NAME OF DEPENDENTS	AMOUNT	OTHER PAYMENTS	AMOUNT
a.			
b.			
c.			
d.			

14. ENTER OTHER PAYMENTS

Attorney Fees		Interest	
Penalty for late payment		TOTAL	

15. Name of Insurance Carrier:
16. Mailing address of Insurance Carrier:
17. Name & signature of Carrier's authorized agent:
18. Date of this notice:

*** FOR STATISTICAL PURPOSES ONLY ***

Please choose one ETHNICITY:

Yapese	Chinese	American
Chuukese	Korean	African American
Kosraean	Japanese	Filipino
Pohnpeian	Chamorro	Other (specify):

Please choose one CITIZENSHIP:

United States
Permanent Resident Alien:
Other (specify):

Form GWC-208: NOTICE of SUSPENSION or TERMINATION PAYMENT of COMPENSATION (Rev Dec 2004)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 * Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File #:

INSTRUCTIONS: Complete this application {Applicant: #1-8/Carrier: #9-12} in duplicate and deliver or mail both to the Office of the Commissioner. If the Commissioner approves this application, it will be forwarded to the Commission for its consideration. [22 GCA 9115(j)].

1. Employee's Name, Address, DOB, & SSN: - -

Home Phone: ( ) **Work Phone: ( )**

2. Applicant's Name, Address, & SSN: - -

3. Date of injury, illness/death:

4. Date of birth (of applicant):

5. Citizenship of Applicant:

6. APPLICATION FOR LUMP SUM AWARD UNDER 22 GCA 9115(j)

A report of my injuries have been filed with the Office of the Commissioner and for which I have been receiving compensation in periodic installments in accordance with the provisions of Law. I request that I be allowed a lump sum payment in an amount equal to the present value of the unpaid compensation due or commuted in accordance with the provisions of 22 GCA 9115(j).

I understand that the liability of the Carrier or my Employer for compensation or any part thereof, except medical care, would be discharged by payment of such lump sum.

My reasons for wanting a lump sum payment are listed below: (NOTE: Give full reason. Include supportive documents, e.g. of employment, experience, on-going business, etc.)

(Use additional sheets if necessary)

7. Signature of Applicant:

8. Date of Application:

TO BE COMPLETED BY THE CARRIER OR REPRESENTATIVE

9. Name of Carrier/ Name & mailing address of Adjuster:

10. Carrier [ ] DOES
[ ] DOES NOT agree to request

11. Signature of Carrier's Representative:

12. Date:

FOR COMMISSIONER/COMMISSION USE ONLY

The Commissioner has determined that lump sum payment: [ ] WILL [ ] WILL NOT be in the interest of Justice

(Signature) (Date)

The Commissioner, during its __________ deliberation [ ] HAS [ ] HAS NOT granted its approval of the request

(Signature) (Date)

* * * FOR STATISTICAL PURPOSES ONLY * * *

Please choose ONE ETHNICITY:

Yapese	Marshallese	Korean
Chuukese	Palauan	Japanese
Kosraean	Chamorro	Chinese
Pohnpeian	Filipino	Other (specify):

Please choose ONE CITIZENSHIP:

United States
Permanent Resident Alien
Other (specify):

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 * Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File #:

INSTRUCTIONS: Use this form to claim for death benefits for WIDOW, WIDOWER, and/or DEPENDENT CHILDREN under the Worker's Compensation Law. Submit claim (in duplicate) to the Office of the Worker's Compensation Commission. FILE WITHIN ONE (1) YEAR of the death of employee, or after it was concluded that death was related to the employment. A person other than the widow, widower, and/or child may complete claim for the beneficiary.

**** NO CLAIM FOR DEATH BENEFIT NEED BE PAID UNLESS A COMPLETED CLAIM FORM HAS BEEN FILED ****

1. Deceased Employee's Name & Address:	2. Employer's Name & Address: EIN #:
3. Date of injury:	4. Place of injury/death:
5. Date of death:	6. Nature/cause of injury/death:

7. CLAIM FOR WIDOW/WIDOWER

a. Name:	b. Date of birth:	c. Citizenship:	d. SSN:

e. Date of marriage to Decedent:	f. Place of marriage:

8. CLAIM FOR UNMARRIED CHILDREN UNDER THE AGE OF EIGHTEEN

** Ethnicity such as: Yapese, Chuukese, Kosraean, Pohnpeian, Marshallese, Palauan, American, African American, Chamorro, Filipino, Korean, Chinese, Japanese, Other (please specify)

a. NAME	b. DATE OF BIRTH	c. CITIZENSHIP	d. ETHNICITY** (Please choose from above examples)	e. SSN
(1)				
(2)				
(3)				
(4)				
(5)				

9. Name and Address of last Physician:	10. Name and Address of Undertaker:

11. Cost of Burial/Funeral:	12. Amount paid:	13. Name of person paying bill:

14. Name and Signature of person completing claim:	15. Address of person completing claim:
16. Date of this claim:	

Form GWC-262: WIDOW'S, WIDOWER'S and/or DEPENDENT CHILDREN'S CLAIM for DEATH BENEFITS (Revision Dec 2004)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P. O. Box 9970 * Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File #:

This form shall be filed with the Worker's Compensation Commission when claiming for funeral and burial expenses. This form or a similar statement must include proof of such expenses. Copies of the form and its attachments should be forwarded to the employer or insurance carrier.

1. Name of decedent:

2. Funeral Home Name, Address, Phone Number:

3. Services performed:	**$**	
TOTAL BILL:	**$**	
AMOUNT PAID:	**$**	
AMOUNT DUE:	**$**	

I was informed that the above bill would be paid by: (Name)

of (address):

His/her relationship to the deceased is:

$ of the bill was paid by (Name)

of (address):

I certify that this concern performed the above services and that no further part of this bill has been paid.

It is therefore request that payment be paid for the services indicated above.

4. Signature and title:	**5. Date:**

Form GWC-265: CERTIFICATION of FUNERAL/BURIAL EXPENSES (Rev Dec 2004)