## 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 #:

	om the date of or know			e Employer to report to the Commissioner subject the Employer to a penalty of up to				
Name of injured En	nployee, DOB & SSN	:	2. Name of Employer & EIN:					
3. Employee's address & telephone no: ( )			4. Employer's address & Telephone no.: ( )					
5. Date & time of alleg	ged injury/illness:		6. Date of Employer's first knowl	edge of injury:				
7. Date & hour Emplo	yee first lost time bec	ause of injury/illness:	Date & hour Employee returned to work:					
9. Date & hour pay st			Days usually worked per week (x days): S M T W TH F S     Average hours per week:					
11. Employee's occup			12. Employee's wages/earnings (overtime, etc):					
13. Is another person	not of your employment [ ] YES [	ent caused the accident?	a. Hourly: \$	b. Weekly: \$				
time of the accident. T	Tell what happened a	DENT OCCURRED: Relate the evend how it happened. Name any objections. Use additional sheets if req	ect or substance involved and tell h	ss. Tell what the injured was doing at the ow they were involved. Give full details on				
15. NATURE OF INJU	JRY/ILLNESS (Name	part of body affected - fractured le	g, bruised arm, lacerated finger, etc	Note any amputations.				
16. Has medical atten authorized?	ition been	17. Date authorized:	18. Has insurance carrier beer notified?	19. Date notified:				
[ ]YES			[ ]YES [ ]NC					
20. Name of treating p	ohysician:		21. Name of insurance carrier:					
22. Name of treating facility:			23. Name & signature of person completing report:					
purpose of obtaining	any benefit or payn neanor and on convi	nent under this Title or for the pu iction thereof shall be punished b		ding statement or representation for the penefit or payment under this Title shall and dollars (\$1,000.00), or by				
24. Title of person cor	npleting report:		25. Date of this report:					
		FOR OTATIOTICAL	BURBOOES ONLY					
Please choose ONE	ETUNICITY	FOR STATISTICAL	. PURPOSES ONLY Please choose ONE CITIZEN	CUID.				
Yapese	Marshallese	African American	United States	SHIF.				
Chuukese	Palauan	Japanese	Permanent Resident Alien					
Kosraean	Chamorro	Chinese	Other (specify):					
Pohnepian	Filipino	American	Culoi (opcony).					
Korean	Other (specify):							

PLEASE CIRCLE THE APPROPRIATE ITEMS (for statistical purposes)											
A. EVENT CODE		***************************************					***************************************				
01 Fatality	02 No Time Loss 03 Time Loss				ss						
B. NATURE OF INJURY CODE											
01 Amputation 02 Asphyxia 03 Bruise/Contusion/Abrasion 04 Burn (Chemical) 05 Burn (Heat) 06 Concussion 07 Cut/Laceration/Puncture	08 Disease/Illness 09 Dislocation 10 Electric Shock 11 Exertion 12 Foreign Body in Eye/Conjunctivitis 13 Fracture 14 Freezing/Frostbite			15 Hearing Loss 16 Hernia 17 Poisoning (Systemic) 18 Puncture 19 Radiation Effects 20 Strain/Sprain 21 Other (Specify)							
C. BODY PART CODE LEFT   RIC	SHT.										
Abdomen 01 Ankle(s): 02 03 Back 04 Body 05 System 06	Abdomen         01         Thumb           Ankle(s):         02         03         Finger           Back         04         (First-Final Control of the c		14 16 17 18 19	15 20 21 22 23	Great Toe Toes (First-Fourth) Ankle		34 36 37 38 39 44	35 40 41 42 43 45			
Chest 07 Head 08 Ear(s) 09 10 Eye(s) 11 12 Face 13	Hand Elbow Arm Should	der	24 26 28 30 32	25 Foot Knee Leg Hip(s)		46 48 50 52	47 49 51 53				
01 Absorption 02 Bite/Sting/Scratch 03 Cardio-Vascular/Respiratory System Failure 04 Caught In or Between	05 Fall (Same level) 06 Fall (From elevation) 07 Ingestion 08 Inhalation 09 Repeated Motion/Pressure			10 Rubbed/Abraded 11 Shock 12 Struck Against 13 Struck By 14 Other (Specify)							
E. SOURCE INJURY CODE  01 Aircraft 02 Air Pressure 03 Animal/Insect/Bird/Reptile/Fish 04 Boat 05 Bodily Motion 06 Boiler/Pressure Vessel 07 Boxes/Barrels, Etc. 08 Buildings/Structures 09 Chemical Liquid/Vapor 10 Cleaning Compound 11 Cold (Environment/Mechanical) 12 Dirt/Sand/Stone 13 Drugs/Alcohol 14 Dust/Particles/Chips	15 Electrical Apparatus/Wiring 16 Explosives 17 Fire/Smoke 18 Food 19 Furniture/Furnishings 20 Gases 21 Glass 22 Hand Tool (Manual) 23 Hand Tool (Powered) 24 Heat (Environmental/Mechanical) 25 Hoisting Apparatus 26 Ladder 27 Machine 28 Materials Handling Equipment			29 Metal Products 30 Motor Vehicle (Highway) 31 Motor Vehicle (Industrial) 32 Motorcycle 33 Person 34 Petroleum Products 35 Pump/Prime Motor 36 Radiation 37 Vegetation 38 Waste Products 29 Water 40 Weapons 41 Working Surface 42 Other (Specify)							
F. CONTRIBUTING ENVIRONMENT  01 Catch Point/Pointer Action  02 Chemical Action/Reaction Expose  03 Flammable Liquid/Solid Expose  04 Flying Object Motion  05 Gas/Vapor/Mist/Fume/Smoke/E  06 Illumination  07 Materials Handling Equipment/I  08 Overhead Moving and/or Falling  09 Overpressure/Underpressure C		10 Pinch Point Action 11 Radiation Condition 12 Shear Point Action 13 Sound Level 14 Squeeze Point Action 15 Temperature Above or Below Tolerance Level 16 Weather/Earthquake, Etc. Condition 17 Working Surface/Facility Layout Condition 18 Other (Specify)									
G. TASK ASSIGNMENT CODE											
01 Employee Working at Regularly		02 Employee \	Working at	OTHER than	Regularly Assigned	d Task(s)					