WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
414 W. Soledad Hagatna, Guam 96910 P.O. Box 9970 Tamuning Guam 96931
Tel: (671)300-4577 and 300-4571 Fax: (671) 475-6811

WCC File#:

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 DOB: SSN:	2. Name of Employer & EIN/ID No: Research Corporation of the University of Guam Ein No.: 980032933
3. Employee's mailing address & telephone no: ( )	4. Employer's mailing address & telephone no.: (671) 735-0336 303 University Drive, UOG Station Mangilao, GU 96913
5. Date of alleged injury/illness:	6. Date of Employer/Carrier's knowledge of injury:
7. Nature of alleged injury/illness:	

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

	a. Temporary Disability during:	8f. Reason(s):
	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 2004)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970 Tamuning, Guam 96931
Tel: (671) 647-6531/2 * Fax: (671) 647-6527

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 authorizaed 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 wilfully 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:
	Research Corporation of the University of Guam 303 University Drive, UOG Station Mangilao, GU 96923
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**	Great National Insurance Underwriters All Insurance Services, Inc. dba: All Insurance Adjustors P.O. Box GA Hagatna, GU 96932 Telephone#646-2250

FOR STATISTICAL PURPOSES ONLY

Employee's ethnicity (please choose one):	***Employee's citizenship (please choose one):***
Yapese Pohnpeian American Korean ***Chuukese Marshalls Chamorro Chinese*** ***Kosraean Palauan Filipino Japanese*** ***Other (specify):***	***U.S.*** ***Permanent Alien Resident*** ***Other (specify):***

FORM GWC-101a: AUTHORIZATION for MEDICAL EXAMINATION and/or TREATMENT (Revised 01/04)

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 wilfully 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."

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
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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: Research Corporation of the University of Guam Ein No.: 980032933
3. Employee's address & telephone no: ( )	4. Employer's address: 303 University Drive, UOG Station Mangilao, GU 96913
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 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:

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	Chamorro	Japanese	Other (specify):
Pohnpeian	Filipino	Korean	
Chinese	Other(specify):		

Form GWC-201: NOTICE of EMPLOYEE'S INJURY/ILLNESS or DEATH (Revised Jan 2004)

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam
P.O. Box 9970, Tamuning, Guam 96931
Tel: (671) 647-6531/2 * Fax: (671) 647-6527

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: Research Corporation of the University of Guam EIN No.: 980032933
3. Employee's address & telephone no: ( )	4. Employer's address & Telephone no.: (671) 735-0336 303 University Drive, UOG Station Mangilao, GU 96913
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 Average hours per week:
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. Weekly: $

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 authorized? [ ] 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:

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):		

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			Toes		
Back	04		(First-Fourth)	16 17 18 19	20 21 22 23	(First-Fourth)	36 37 38 39	40 41 42 43
Body	05							
System	06		Wrist	24	25	Ankle	44	45
Chest	07		Hand	26	27	Foot	46	47
Head	08		Elbow	28	29	Knee	48	49
Ear(s)	09	10	Arm	30	31	Leg	50	51
Eye(s)	11	12	Shoulder	32	33	Hip(s)	52	53
Face	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
	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 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)

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Tel: (671) 647-6531/2 * Fax: (671) 647-6527

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: Great National Insurance Underwriters All Insurance Services, Inc. dba: All Insurance Adjustors P.O. Box GA Hagatna, GU 96932 Telephone#646-2250

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: 303 University Drive, UOG Station Mangilao, GU 96913	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:

*** * * FOR STATISTICAL PURPOSES ONLY * * ***

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