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# WORKER'S COMPENSATION COMMISSION

**Department of Labor * Government of Guam * P.O. Box 9970 Tamuning, Guam 96931**

**Tel: (671) 475-7033/4 * Fax: (671) 475-7026**

**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.**

**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: |
|---|---|
| **WORKER'S COMPENSATION COMMISSION<br>P.O. Box 9970<br>Tamuning, Guam 96931** | **Same as Item # 13 unless otherwise specified** |

***FOR STATISTICAL PURPOSES ONLY:***

| *Employee's ethnicity (please choose one):* | *Employee's citizenship (please choose one):* |
|---|---|
| *Yapese* ☐ *Pohnpeian* ☐ *American* ☐ *Korean* ☐<br>*Chuukese* ☐ *Marshalls* ☐ *Pacific Islander* ☐ *Chinese* ☐<br>*Kosraean* ☐ *Palauan* ☐ *Filipino* ☐ *Japanese* ☐<br>*Other (specify):* | *U.S.* ☐<br>*Permanent Alien Resident* ☐<br>*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:**<br>**Admission date:**<br>**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):**<br>**Partial Disability: From To**<br>**Total Disability: From To** | **29. Date Employee was able to resume work:**<br>**LIGHT WORK ☐**<br>**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 |
|---|---|---|---|---|
| | | | | |

**Form GWC-101b Revised (01/2004)**