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WORKERS' COMPENSATION COMMISSION

NMI RETIREMENT FUND

P.O. Box 501247, Saipan, MP 96950
Phone: (670) 664-8024 / Fax: (670) 664-8074

WCC FILE #: _____
CARRIER'S #: _____
EMPLOYER'S #: _____

AUTHORIZATION FOR MEDICAL EXAMINATION AND/OR TREATMENT

(To Be Completed By Employer)

INSTRUCTION: *This side should be completed in full. It authorizes a physician (duly qualified physicians include surgeons, osteopathic practitioners, and acupuncturists within the scope of their practice as defined by law) of the employee's choice to examine and/or treat the employee for the injuries arising out of such accidental occupational injury, illness, or disease covered by the CNMI Workers' Compensation Law.*

1. Name of authorized physician	2. Name of Medical Facility:	
3. Physician's Address:	4. Medical Facility's Address:	
5. Name of Injured Employee: S.S. No.:_____-_____-_____	6. Occupation:	7. Date of Injury:

8. Description of Injury:

9. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS:

☐ If you believe the condition Is related to the Injury, furnish necessary treatment.

☐ 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 diagnostics studies, and promptly advise the carrier indicated In Item 14 whether you believe the disability Is due to the alleged Injury. Pending further advice, you may provide such necessary conservative treatment.

☐ Other (Specify)

YOU ARE REQUESTED TO SUBMIT A WRITTEN REPORT OF FIRST TREATMENT WITHIN 20 DAYS TO THE ADMINISTRATOR AT THE ADDRESS INDICATED IN ITEM 13. (See *back of this form for instructions as to medical report and the submission of your* charges). Reports are required if services are to be paid.

10. Signature and title of Authorizing Official	11. Name and Address of Employer:
12. Date:	
13. Send your REPORT to: **CNMI Workers' Compensation Commission** **P.O. Box 501247 C.K.** **Saipan, MP 96950**	14. Name and Address of Insurance Carrier to whom COPY of your REPORT and BILL are to be sent:

ATTENDING PHYSICIAN'S INITIAL REPORT OF INJURY AND TREATMENT

INSTRUCTIONS TO PHYSICIAN: *This initial report should be completed and mailed within 20 days, the original to the Administrator (See item 13 for address), with a copy to the Company in item 14. Subsequent reports should be made regularly on Form WCC-201 or in narrative form while employee is in your care. Please read item 9 on the front of this form..*

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

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)*

20. Did injury require hospitalization? ☐ No ☐ Yes

Hospital:

Admission Date:

Discharge Date:

21. Is additional hospitalization required?

☐ No ☐ Yes

22. Surgery (if any, describe):

Date performed:

23. Other types of treatments:

24. What PERMANENT DEFECTS do you anticipate?

25. Date of first examination:

26. Date of Treatments:

27. Dates of discharge:

28. Period of TEMPORARY DISABILITY *(Indicate* if unknown)

Partial Disability: From To

Total Disability: From To

29. Date Employee able to resume work.

☐ LIGHT ☐ REGULAR

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 that could reasonably be performed with limitations:

32. General remarks and RECOM-MENDATIONS for future care, if indicated:

33. Do you SPECIALIZE? ☐ No ☐ Yes *(Specify)*

34. Name and 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 of Treatment	Service/Supplies MUST be itemized	Quantity	Unit Price	Amount

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PHYSICIAN'S REPORT FOR SUBSEQUENT TREATMENT

INSTRUCTIONS: *This form is to be used for subsequent treatment, to make progress reports and final report when the patient is discharged. Aft questions must be answered fully. Write "NA" if not applicable. The exact point of amputation and other permanent. partial disabilftles must be known in order to determine compensation due the injured employee accordng tothe PPD schedule provided by law. The back of this form may be used if needed The physician may submit a narrative report covering all the questions and information asked for in this form on separate sheets. This report is required by 4 CMC 9307(a).*

1. Name of injured employee:	2. Date of injury:	
3. Employee's address:	4. Date of Birth (Mo/Da/Yr)	5. Sex:
6. Name of Employer:	7. Employer's Address:	
8. Date first visit:	9. Date of discharge:	10. Who authorized treatment?
11. Nature of treatment:		12. Dates of your treatment:
13. Was employee hospitalized? ☐ Yes ☐ No (If yes, respond in item 15).	14. Were X-rays taken? ☐ Yes ☐ No (If yes, give result in #17)	

15. Give names, addresses, and dates of treatments provided by hospitals or other doctors for this injury:

16. Employee's account of how injury or exposure to occupational disease occurred:

17. Finds upon examination (Include results of X-rays, laboratory studies, etc. Note prior injuries and existing conditions and any remarks and recommendations on the reverse side of this form).

18. Diagnosis:	19. Is diagnosed condition due to occurrence described in item 16? (If no, explain on reverse side of this form) ☐ Yes ☐ No

20. Was there disability for work? ☐ Yes ☐ No If yes, answer >>>	A. Date disability began:	B. Date able to return to light work	C. Date able to return to regular work:

21. Will there be permanent defect, or facial or head disfigurement? If yes. describe briefly and estimate loss in % terms.
☐ Yes ☐ No

22. Name of attending physician:	23. Address:
24. Signature of physician	25. Date of this report:

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NOTICE OF EMPLOYEE'S INJURY OR ILLNESS

(To Be Completed By Employee)

INSTRUCTIONS: *This form may be used by the EMPLOYEE to file a NOTICE OF INJURY or ILLNESS, or in the case of death, by the EMPLOYEE'S representative. No benefits need to be paid without this notice. Notice shall be given to the Administrator and to the Employer by delivery or mail to the last known address. This notice is required by 4 CMC 9321.*

THIS IS NOT A CLAIM FOR COMPENSATION

1. Name of injured employee: S.S.N.:	2. Name of Employer: Fed. ID. No.:
3. Employee's Address & Phone No.:	4. Employer's Address
5. Date and Time of Alleged Injury/illness:	6. Did employee stop work? If yes, date stopped: ☐ Yes ☐ No
7. Employee's Occupation:	8. Name of Supervisor at the time of injury:
9. Place where injury occurred:	
10. Is another person (not your fellow employee) the cause of the accident/injury? ☐ Yes ☐ No	11. If you answer "Yes" to item 10, will you file a 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 factors which led or contributed to the accident.)

(Use additional sheets if necessary and attach to this Notice)

13. Effects of the injury (Indicate parts of body affected and how affected)

14. Employee's Signature	16. Print name of person completing this form:
15. Signature of person completing this Notice:	17. Date of this Notice

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EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

(To Be Completed By Employer)

INSTRUCTIONS: *This form may be used by the Employer to report an injury or illness. 4 CMC 9339 requires the Employer to report to the Administrator within 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 civil penalty of up to $500.00.*

1. Name of injured employee: S.S.N.:	2. Name of Employer: Fed. ID. No.:
3. Employee's Address & Phone No.:	4. Employer's Address
5. Date and Time of Alleged Injury/illness:	6. Date of Employer's first knowledge of injury:
7. Date & hour Employee first lost time because of injury or illness:	8. Date & hour Employee returned to work:
9. Date & hour pay stopped:	10. Days usually worked per week (Circle days): ☐ ☐ ☐ ☐ ☐ ☐ ☐ Sun Mon Tue Wed Thu Fri Sat
11. Employee's occupation:	12. Employee's wages/earnings (overtime, etc.) a. Hourly: $ _____ b. Daily: $ _____
13. Is there another person not of your employment that caused the accident? ☐ Yes ☐ No	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 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 necessary and attach to this Notice)

15. NATURE OF INJURY/ILLNESS (Name part of body affected, i.e. fractured leg, bruised arm, 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 of person completing this report:
24. Title of person in item 23:	25. Signature of person in item 23 and Date of this report:

PLEASE CIRCLE THE APPROPRIATE ITEMS *(For statistical purposes)*

A. Nature of Injury

01 Fatality | 02 No Time Loss | 03 No Time Loss

B. Nature of Injury Code

01 Amputation	08 Disease/Illness	15 Hearing Lass
02 Aspysxis	09 Dislocation	16 Hermia
03 Brulse/Contusion/Abrasion	10 Electric Shock	17 Poisoning (Systemic)
04 Burn (Chernical)	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	14 Freezing/Frostbite	21 Other (Specify)

C. Body Part Code

61 Abdomen	09 Face	17 Lower Arm(s) [ ] Left [ ] Right
02 Ankles [ ] Left [ ] Right	10 Finger(s) 1 2 3 4 5 6 7 8 9 10	18 Lower Leg(s) [ ] Left [ ] Right
03 Back	11 Foot/Feet [ ] Left [ ] Right	19 Neck
04 Body System	12 Hand(s) [ ] Left [ ] Right	20 Shoulder(s) [ ] Left [ ] Right
05 Chest	13 Head	21 Toe(s) 1 2 3 4 5 6 7 8 9 10
06 Ear(s) [ ] Left [ ] Right	14 Hip(s) [ ] Left [ ] Right	22 Upper Arm(s) [ ] Left [ ] Right
07 Elbows(s) [ ] Left [ ] Right	15 Knee(s) [ ] Left [ ] Right	23 Upper Leg(s) [ ] Left [ ] Right
08 Eye(s) [ ] Left [ ] Right	16 Leg(s) [ ] Left [ ] Right	24 Wrist(s) [ ] Left [ ] Right

D. Type of Even Code

01 Absorption	06 Fall (From elevation)	11 Shock
02 Bite/Sting/Scratch	07 Ingestion	12 Struck Against
03 Cardio-Vascular/Respiratory Failure	08 Inhalation	13 Struck By
04 Caught In or Between	09 Repeated Motion/Pressure	14 Other (Specify)
05 Fall (Same Level)	10 Rubbed/Abraded	

E. Source of Injury Code

01 Aircraft	15 Electrical Apparatus/Wiring	29 Metal Products
02 Air Pressure	16 Explosives	30 Motor Vehicles (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/Prlme 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 (Environmental/Mechanical)	25 Hoisting Apparatus	39 Water
12 Dirt/Sand/Stone	26 Ladder	40 Weapons
13 DrugstAlcohol	27 Machine	41 Working Surface
14 Dust/Particles/Chips	29 Materials Handling Equipment	42 Other (Specify)

F. Contributing Environmental Factor Code

01 Catch Point/Pointer Action	07 Materials Handling Equipment	13 Sound Level
02 Chemical Action/Reaction Exposure	08 Overhead Moving and/or Failing Object	14 Squeeze Point Action
03 Flammable Liquid/Solid Exposure	09 Overpressure/Underpressure Condition	15 Temperature Above/Below Tolerance Level
44 Flying Object Motion	10 Pinch Point Action	16 Weather/Earth quake, Etc., Condition
05 Gas Vapor/Mist/Fume/Dust Condition	11 Radiation Condition	17 Working Surface/Facility Layout Condition
06 Illumination	12 Shear Point Action	18 Other (Specify)

G. Task Assignment Code

01 Employee Working at Regularly Asdgned Task(s) | 02 Employee Working at OTHER than Regularly Assigned Task(s)

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EMPLOYEE'S CLAIM FOR COMPENSATION

INSTRUCTION: This *form should be completed by the EMPLOYEE when filing a CLAIM FOR COMPENSATION. 4 CMC 9322 requires the filing of a claim within one year after the date of injury or the date of last payment of compensation.*

PENALTY FOR MISREPRESENTATION: *Any person who willfully makes any false or misleading statement or representation forth & purpose of obtaining any benefit or payment under the Workers' Compensation Law shall be guilty of a misdemeanor, and upon conviction thereof, be fined not more than $ 1,000, or imprisoned for not more than 1 year, or both. (4 CMC 9340)*

ROTA AND TINIAN EMPLOYEES: *This form may be filed with the local WCC/NMIRF office.*

1. Name of injured employee: S.S.N.:	2. Name of Employer: Fed. ID. No.:
3. Employee's Address & Phone No.:	4. Employer's Address
5. Date and Time of Alleged Injury/Illness:	6. Date of Employer's first knowledge of injury/Illness:
7. Date & hour Employee first lost time due to injury /illness:	8. Date & hour Employee returned to work:
9. Date & hour pay stopped:	10. Days usually worked per week (overtime, etc.): (Circle) ☐ ☐ ☐ ☐ ☐ ☐ ☐ Sun Mon Tue Wed Thu Fri Sat
11. Employee's occupation:	12. Employee's wages/earnings (overtime, etc.) a. Hourly: $ _____ b. Daily: $ _____ c. Weekly: $ _____ d. Yearly: $ _____
13. Is there another person (not your fellow employee) the cause of the accident? ☐ Yes ☐ No	14. Will a third party suit be filed? ☐ Yes ☐ No

15. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED. (Relate the events which resulted in the injuryAllness. Explain what you were doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and how they were involved.)

(Use additional sheets if necessary and attach to this Notice)

16. NATURE OF CLAIM FOR COMPENSATION: ☐ Temporary Disability (wage/salary lost) ☐ Permanent Disability (physical loss/loss use of) ☐ Disfigurement (serious head/facial) ☐ Other	EXPLAIN:
17. Have you received medical attention for your Injury? ☐ Yes ☐ No	18. If yes, give name and address of treating Physician/clinic:
19. Name and Signature of Employee:	20. Date:

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AUTHORIZATION TO RELEASE INFORMATION

To whom it may concern:

I,_____a resident of

_____ whose Social Security Number is _____,

do hereby authorize and request the release of all information (as checked below) to any employee of the CNMI Workers' Compensation Commission:

- ( ) Medical record
- ( ) Police record
- ( ) Commerce/Labor records
- ( ) Employment record
- ( ) Immigration document
- ( ) Other_____ (please specify)

I do understand that the information requested above will be used strictly for Workers' Compensation purposes. I hereby expressly waive the privilege of confidentiality and right of privacy set forth in the applicable United States and Commonwealth laws. A copy of this authorization shall have the same force and effect as the original.

Dated this _____day of_____,20_____

_____ Signature of person authorizing

_____ Signature of witness

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EMPLOYER'S SUPPLEMENTARY REPORT OF AN INJURY

INSTRUCTION: This form should be completed by the EMPLOYER and filed promptly with the Administrator, within 10 days from the date the employee returned to work in every case in which the date the injured employee returned to work is not indicated in From WCC-203-A

ROTA AND TINIAN EMPLOYERS: *This form may be filed with the local WCC/NMIRF office.*

1. Name of injured employee: S.S.N.:	2. Name of Employer: Fed. ID. No.:
3. Employee's Address & Phone No.:	4. Employer's Address
5. Date of Injury/Illness:	6. Date of Employer's first knowledge of injury/Illness:

7. Initial period of illness/disability. (Use inclusive dates for a and b.

a. From (Month, Day, Year)	b. To (Month, Day, Year)	c. Date returned to work (Month, Day, Year)

8. If this report covers a period of illness/disability after the date shown on item 7c, state each subsequent period of illness/ disability. Use inclusive dates for a and b.

a. From (Month, Day, Year)	b. To (Month, Day, Year)	c. Date returned to work (Month, Day, Year)

9. Did employee receive medical attention? ☐ a. Yes. Give dates, names and addresses of doctors and hospitals providing treatment	☐ b. No. Explain
10. Was employee treated by his or her choice of physician? ☐ Yes ☐ No	11. Was Form WCC-203-A given to employee when the injury/illness was reported to employer. ☐ Yes ☐ No

12. Name and Signature of person completing this form:	13. Title	14. Date:

CLAIM FORMS PROCEDURE:

1. WCC-200A - Authorization for Medical Examination and/or Treatment (Employer will prepare the Authorization for Medical treatment, to be given to the treating facility)

2. WCC-200B - Attending Physician's Initial Report of Injury and Treatment

3. WCC-201 - Physician's Report for Subsequent Treatment

4. WCC-202 - Notice of Employee's Injury or Illness (to be completed by Employee)

5. WCC-203 - Employer's Report of Occupational Injury or Illness (to be completed by Employer)

6. WCC-204 - Employee's Claim for Compensation (to be completed by Employee)

7. WCC-205 - Authon*zation to Release Information (to be completed by Employee)

8. WCC-206 - Notice by Employer to Controvert the Right to Compensation (to be completed by Employer) if the employer or carrier believes the injury is not work-related and denies liability for compensation)

9. WCC-207 - Employer's Supplementary Report of an Injury (to be completed by Employer)

I 0. Employer's Incident/Accident Report of the Injury

I 1. Copy of Illness Certification Slip from the Physician

12 Copy of approved Leave Application related to the injury

13. Copy of Time Attendance Record for the period of the injury

14. Original medical claims

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NOTICE OF FIRST PAYMENT, SUSPENSION OR FINAL PAYMENT OF COMPENSATION

INSTRUCTIONS: *This notice must be filed by the carrier with the Administrator within* **15 days** *after the first or final payment of compensation has been made. If payment is being suspended, or stopped for modification, and will later be reinstated, or continued, indicate in item H, and give reasons. This form is to be used for disability or death benefits.*

Please check applicable box:

- ☐ **First Payment**
- ☐ **Suspension of Payment**
- ☐ **Final Payment**

1. Name of employee:	2. Date of this notice	
3. Employee's address:	4. Date of Injury:	5. Sex:
6. Name of Employer:	7. Employer's address:	
8. Date Employee first lost pay due to injury:	9. Date physician found employee able to return to work:	10. Date employee return to work:
11. State reason(s) for suspension or termination of payment:	12. Date of first payment:	
	13. Date of last payment:	

14. ENTER DISABILITY PAYMENTS

TYPE OF DISABILITY	FROM	TO	AMOUNT PER WK.	NO. WKS.	TOTAL
			TOTAL		

15. ENTER ALL PAYMENTS MADE ON ACCOUNT OF DEATH

Name of Dependents	Amount	TOTAL
(Use additional sheets if necessary)	TOTAL	

15. OTHER EXPENSES

Name of Dependents	Amount	TOTAL
(Use additional sheets if necessary)	TOTAL	

16. Name of carrier:	17. Address of carrier:
18. Name and title of person preparing this report:	19. Signature: