Department of Commerce

WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 5795 CHRB, Saipan MP 96950
Tel: (670) 664-8018/8024 • Fax (670) 664-8074
Website: www.commerce.gov.mp

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

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:	

ENTER DISABILITY PAYMENTS

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

ENTER ALL PAYMENTS MADE ON ACCOUNT OF DEATH

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

OTHER EXPENSES

15. 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: