



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 #: _____



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:		6. Occupation:	7. Date of Injury:
S.S. No.: _____ - _____ - _____			
8. Description of Injury:			
9. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS:			
<input type="checkbox"/> If you believe the condition is related to the Injury, furnish necessary treatment.			
<input type="checkbox"/> 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.			
<input type="checkbox"/> 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 <u>are required</u> 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 5795 CHRB 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 RECOMMENDATIONS 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. All questions must be answered fully. Write "NA" if not applicable. The exact point of amputation and other permanent partial disabilities must be known in order to determine compensation due the injured employee according to the 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, respond in item 15).	14. Were X-rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Was there disability for work? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No			
22. Name of attending physician:		23. Address:	
24. Signature of physician		25. Date of this report:	



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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): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 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 of your employment that caused the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Date Authorized:	18. Has Insurance Carrier been notified <input type="checkbox"/> Yes <input type="checkbox"/> 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 Time Loss

B. Nature of Injury Code

01 Amputation

02 Asphyxia

03 Bruise/Contusion/Abrasion

04 Burn (Chemical)

05 Burn (heat)

06 Concussion

07 Cut/Laceration

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

01 Abdomen

02 Ankles Left Right

03 Back

04 Body System

05 Chest

06 Ear(s) Left Right

07 Elbows(s) Left Right

08 Eye(s) Left Right

09 Face

10 Finger(s) 1 2 3 4 5 6 7 8 9 10

11 Foot/Feet Left Right

12 Hand(s) Left Right

13 Head

14 Hip(s) Left Right

15 Knee(s) Left Right

16 Leg(s) Left Right

17 Lower Arm(s) Left Right

18 Lower Leg(s) Left Right

19 Neck

20 Shoulder(s) Left Right

21 Toe(s) 1 2 3 4 5 6 7 8 9 10

22 Upper Arm(s) Left Right

23 Upper Leg(s) Left Right

24 Wrist(s) Left Right

D. Type of Event Code

01 Absorption

02 Bite/Sting/Scratch

03 Cardio-Vascular/Respiratory 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 of 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 (Environmental/Mechanical)

12 Dirt/Sand/Stone

13 Drug/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

29 Materials Handling Equipment

29 Metal Products

30 Motor Vehicles (Highway)

31 Motor Vehicle (Industrial)

32 Motorcycle

33 Person

34 Petroleum Products

35 Pump/Prime Motor

36 Radiation

37 Vegetation

38 Waste Products

39 Water

40 Weapons

41 Working Surface

42 Other (Specify)

F. Contributing Environmental Factor Code

01 Catch Point/Pointer Action

02 Chemical Action/Reaction Exposure

03 Flammable Liquid/Solid Exposure

04 Flying Object Motion

05 Gas Vapor/Mist/Fume/Dust Condition

06 Illumination

07 Materials Handling Equipment

08 Overhead Moving and/or Falling Object

09 Overpressure/Underpressure Condition

10 Pinch Point Action

11 Radiation Condition

12 Shear Point Action

13 Sound Level

14 Squeeze Point Action

15 Temperature Above/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 Assigned Task(s)

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



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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:

- | | |
|---|---|
| <input type="checkbox"/> Medical record | <input type="checkbox"/> Employment record |
| <input type="checkbox"/> Police record | <input type="checkbox"/> Immigration document |
| <input type="checkbox"/> Commerce/Labor records | <input type="checkbox"/> 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 Form WCC-203-A

ROTA AND TINIAN EMPLOYERS: *This form may be filed with the local WCC/DOC 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)
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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 - Authorization 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