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 #: _____

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 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/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 (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)