# *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 #: ____________

## 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/DOC office.*

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| 1. Name of injured employee:<br><br>S.S.N.: | 2. Name of Employer:<br><br>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)<br>☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat |
| 11. Employee's occupation: | 12. Employee's wages/earnings (overtime, etc.)<br>a. Hourly: $ ________ b. Daily: $ ________<br>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)

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| 16. NATURE OF CLAIM FOR COMPENSATION:<br>☐ Temporary Disability (wage/salary lost)<br>☐ Permanent Disability (physical loss/loss use of)<br>☐ Disfigurement (serious head/facial)<br>☐ 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: |

FORM WCC-204 (REV. &W Replaces Form CWC-203)