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 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/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)

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: