MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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Form WCA - 103
(Schedule 10 of the Workers' Compensation Regulations)

Notice of Payment or Suspension/Termination of Payment

This notice must be submitted by the employer (or insurance carrier) to the Administrator within 15 calendar days after initial payment of compensation. This form is also to be used if employer was ordered to pay the injured worker direct given their failure to cover the employee with worker's compensation insurance.

1 Name of injured worker	2 Name of employer	3 Check if applicable [ ] First Payment [ ] Most recent payment [ ] Final Payment [ ] Suspension of Payment [ ] Termination of payment
4 Worker's address	5 Employer's address	
6 Date of injury	7 Date when worker is medically cleared to return to work	8 Date worker first lost pay due to injury
9 Date worker actually returned to work	10 Number of available VL/SL hours	11 Date of 1st payment
12 Reason(s) for suspension or termination of wages (attach supporting documents)		13 Date of last payment

14 Summary of Disability Payments (use additional sheets if necessary)

Disability type	From	To	Amount/week	# of weeks	Total Amount
Total					

15 Other Expenses (Use additional sheets if necessary)

Name of Dependents	Amount	Total

16 Name of insurer	17 Position title of person completing report	18 Date of this report
19 Signature of person completing this report	20 Remarks	