MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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Form WCP - 202
(Schedule 16 of the Workers' Compensation Regulations)

NOTICE CONTESTING DENIAL OF CLAIM FOR COMPENSATION

To be filed by the Worker or Representative within 15 calendar days after receipt of Compensation Order denying the claim by the Administrator. The Worker must provide evidence not previously presented to the Administrator supporting the appeal to the Worker's Compensation Board for reconsideration.

1. Name of worker/SS number	2. Name of employer/EIN
3. Worker's address & contact phone no.	4. Employer's address & contact phone no:
5. worker's occupation or job role	6. Date of first knowledge of injury/illness
7. The undersigned hereby appeals to the Workers' Compensation Board to reconsider the Administrator's decision denying the claim for worker's compensation. THE WORKER MUST STATE THE GROUNDS UPON WHICH THE DENIAL OF A CLAIM TO COMPENSATION IS CONTESTED (*see notes below). I am submitting the following new and additional evidence as proof that my/our claim is valid: (use another sheet if necessary and attach to this form)	
8. Name and signature of worker/claimant Name Signature	9. Date of this Notice
10. Name, signature & title of representative of worker Date:	11. Mail/Hand-deliver this notice to: **The Administrator** RMI Workers' Compensation Administration P.O. Box 175, Majuro MH 96960 Marshall Islands (MISSA Office)

***NOTES of information to provide:**

1. Initial period of illness/disability

2. Date worker returned to work

3. Did the worker receive medical attention? If yes, give dates and names of physician/hospital. If no, explain why not?

4. Was the worker treated by his choice of physician? Yes or no.

5. Was form WCP-200 Notice of Injury filled out by the worker when the injury/illness first occurred and was it reported to employer? Yes or no.