MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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Form WCA – 101

(Schedule 18 of the Workers' Compensation Regulations)

Employer's Report of Worker's Injury/Illness/Death

(To be submitted by the employer to the Administrator and Insurance Carrier within 10 calendar days after date of injury or death). A copy of the certificate of compliance must be attached as proof that the injured or deceased worker is covered by a valid worker's compensation insurance policy.)

Name of injured employee:	Name of employer:
Social Security No:	EIN No:
Employee's address & contact no.	Employer address & contact no:
Citizenship:	With valid Health Card? [ ] Yes [No] Health card expiry date:
Date & time of injury or death:	Date of employer's first knowledge of injury or death:
Date & time employee stopped working due to injury/death:	Date& time employee returned to work:
Date & time pay stopped:	Employee's regular weekly work schedule: [ ]Su [ ]M [ ]T [ ]W [ ]Th [ ]F [ ]Sa
Employee's occupation:	Employee's basic earnings + regular overtime: Hourly: $..... Daily: $.....
Was there someone else other than the employee that caused the accident: [ ] Yes [ ] No	Weekly: $..... Yearly: $.....
Describe in detail how the accident occurred. Tell what the injured or deceased employee was doing at the time of the accident. State if there was a witness during the accident and get his/her statement in writing. Use additional sheet(s) as necessary.	
Nature of injury/illness (name part of body affected, i.e. fractured leg, bruised arm, burned face, etc.)	
Has medical attention been authorized? [ ] Yes [ ] No Date authorized:	Was insurance carrier notified? [ ] Yes [ ] No Date notified:
Name of attending physician/Hospital location	Name of insurance carrier:
Name of person and title completing this report:	Signature and date of this report: