MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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FORM WCP – 205
(Schedule 19 of the Workers' Compensation Regulations)

APPLICATION FOR PERMANENT TOTAL DISABILITY BENEFITS

To be filed by the employee within 10 days after final diagnosis is made known from the attending physician. This may be submitted prior to receipt of payment from insurance carrier or employer. A copy of the Attending Physician's Report and Recommendations (Form WCA-602) must be attached to this form prior to submission to the WCA.

To : WCA Administrator

Due to the seriousness of the injury that I sustained, I am applying for permanent disability benefits under the Workers' Compensation Program.

1. Name of injured worker:	2. Name of employer:
3. Social Security No:	4. Worker's date of birth:
5. Worker's mailing address & contact no.	6. Employer's mailing address & contact no:
7. Date & time of injury or illness:	8. Place where injury or incident occurred:
9. Date & time worker stopped working due to injury or illness	10. Worker's occupation:
11.Describe in detail how the incident occurred and the effect(s) of the injury sustained. (Name part of body affected, i.e. fractured leg, bruised arm, burnt face, etc.). Use an extra sheet if necessary.	
12. Doctor's diagnosis and recommendations (must be copied from the Attending Physician's Report and Recommendations (Form WCA-602)	
13. Signature of injured worker	15 If worker can't fill-up this form, indicate the name and signature of representative who completed this form:
14. Date of this application:	