MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

Head Office
P.O. Box 175, Majuro, Marshall Islands MH 96960
Phone: (692) 625-3101, Fax: (692) 625-4570
Email: rmiworkcomp@rmimissa.org
www.rmiworkcomp.org

Ebeye Branch
P.O. Box 5850, Ebeye, Kwajalein, MH96970
Phone: (692) 329-3788, Fax: 329-3902
Email: missaebeye@rmimissa.or

Form WCA- 102
(Schedule 29)

AUTHORIZATION FOR MEDICAL EXAMINATION AND TREATMENT

(To be completed by the Employer before injured worker is taken to the hospital for medical examination & treatment)

1. Name of injured worker/ SSS No.	2. Name of employer/EIN No.	
3. Name of Medical facility: [ ]Majuro Hosp [ ] Ebeye Hosp [ ] Other_____		4. Name of Physician:
5. Occupation/role of injured/ill worker	6. Date & time of injury/illness	7. Place of injury/illnes
8. Citizenship of injured/ill worker:	9. With valid MoH Health Card? [ ] Yes [ ] No Health card expiry date:	10. With Supplemental Health Plan? [ ] Yes [No]

11. Brief description of injury/illness:

12. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE ABOVE SUBJECT-WORKER:

- If you believe that the condition is related to the injury or illness, please state the diagnosis in your report and provide necessary treatment/plan.
- If there is doubt that the condition is related to the work incident, please also state in your report. You are still authorized to examine and treat the employee and indicate in # 5 whether you believe the disability is due to the alleged incident or not.
- Other (please specify):

13. **PLEASE SUBMIT A WRITTEN REPORT OF FIRST TREATMENT AND DIAGNOSIS WITHIN 15 WORKING DAYS TO THE ADMINISTRATOR AT THE ADDRESS INDICATED BELOW** (see attached FORM WCA-600 for instructions).

14. Name and signature of authorizing official:	15. Position title	16. Date;

17. Please send your report to: The Administrator RMI Workers' Compensation Administration P.O. Box 175, Majuro, Marshall Islands MH 96960	18. Name and address of Insurance carrier to whom copy of your report is to be sent: