MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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Form WCA – 200

(Schedule 2 of the Workers' Compensation Regulations)

NOTICE OF WORKER'S INJURY OR ILLNESS/DEATH & REQUEST FOR MEDICAL TREATMENT AND SERVICES

(To be completed by worker or his representative within 30 calendar days after date of injury or illness. The original must be given to the Administrator and a copy is provided to the employer)

To: MISSA/WCA Administrator: This is to formally request for medical treatment and services in relation to my injury/illness as described below:

1. Name of injured/deceased 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. Citizenship of worker (for Medical referral purposes)	8. With valid MOH Health Card? [ ] Yes [ ] No Health card expiry date:
9. Date & time of injury or illness/death:	10. Place where injury or incident occurred:
11. Date & time worker stopped working due to injury or illness/death	12. Name of supervisor at time of injury or illness/death:
13. Worker's occupation:	14.Was there someone else other than the worker that caused the incident: [ ] Yes [ ] No If yes, who? …….
15.Describe in detail how the incident occurred. Tell what the injured worker was doing at the time of the incident. State if there was a witness during the incident and get his statement in writing. Use additional sheet(s) if necessary.	
16.Effect(s) of the injury or illness. (Name part of body affected, i.e. fractured leg, bruised arm, burnt face, etc.)	
17. Injured/deceased Worker's/representative signature	If worker can't fill-up this form, indicate the name and signature of representative who completed this form:
18. Date of this notice:	
Claim Number (generated by MISSA)	Filed by (MISSA Officer)