MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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Form WCA-104
(Schedule 30)

Injured/Ill Worker's Return to Work Report

(To be filed by employer within 10 days after the injured employee has returned to work)

Name of injured worker:		Name of employer:	
Social Security No:	Worker's date of birth	EIN No:	
Worker's mailing address:	Worker's contact no.	Employer's mailing address:	Employer's contact no.
Date of injury/illness:		Nature of injury/illness:	

Initial period of disability: From: MM/DD/YR	To: MM/DD/YR	Date worker returned to work: MM/DD/YR

If this report covers a period or multiple period of disability after initial period of disability, state each subsequent period of disability. This applies if there is a recurrence of the same disability after initial period of injury.

From: MM/DD/YR.. To: MM/DD/YR.. Date returned to work..

From: MM/DD/YR.. To: MM/DD/YR.. Date returned to work..

From: MM/DD/YR.. To: MM/DD/YR.. Date returned to work..

Did injured/ill worker receive medical attention: If yes, give details Dates: From.. To:.. Dame of doctor:... Name of hospital:	Did injured/ill worker receive medical attention: If No, explain.
Did injured/ill worker receive workmen's compensation? If yes, state amount and for how many days Amount.......................... No. of days................................. From: MM/DD/YR............................... To:...	Did injured/ill worker receive workmen's compensation? If No, state the reason(s):
Name of person and title completing this report:	Signature and date of this report: