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.org

Form WCA - 201

(Schedule 6 of the Workers' Compensation Regulations)

WORKER'S CLAIM FOR COMPENSATION

(To be filed within one year after date of injury/illness/death or date of last payment of "salary from employer"

1. Name of injured worker/ SSS No.	2. Name of employer:
3. Worker's mailing address & contact no.	4. Employer mailing address & contact no:
5. Worker's Citizenship (for medical referral purposes):	6. With valid Health Card? [ ] Yes [No] MOH Health card expiry date:
7. Date & time of injury/illness/death:	8. Date of employer's first knowledge of injury:
9. Date & time worker stopped working due to injury/illness/death:	10. Date & time worker returned to work:
11. Date & time pay stopped:	12. Worker's regular weekly work schedule: [ ]Su [ ]M [ ]T [ ]W [ ]Th [ ]F [ ]Sa
13. Worker's occupation/role:	14. Worker's basic earnings + regular overtime: Hourly: $.................... Daily: $............................
15. Was there someone else other than the worker that caused the incident: [ ] Yes [ ] No	Weekly: $................. Yearly: $........................

16. 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/her statement in writing. Name part of body affected, i.e. fractured leg, bruised arm, burnt face. Use additional sheet(s) if necessary.

17. TYPE OF CLAIM FOR COMPENSATION [ ] Temporary disability (lost wages) [ ] Permanent disability (loss use of _______________) [ ] Disfigurement (serious head/facial) [ ] Other :	Explain:
18. Did you receive treatment/medical attention? [ ] Yes [ ] No Date: From:............................ to:................................	19. If yes, give name of treating physician and hospital

20. Name & signature of worker/date:	21. If worker can’t fill-up this form, indicate name & signature of person completing this form
22. Medical Report attached	23. Date of Medical Report
24. Claim Number (from MISSA)	25. Filed by (MISSA)