



PORT AUTHORITY OF GUAM
ATURIDAT I PUETTON GUAHAN
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GOVERNMENT OF GUAM

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FELIX P. CAMACHO
Governor of Guam

MICHAEL W. CRUZ
Lieutenant Governor

POLICY MEMORANDUM NO. 05-88

To: Port Employees	Subject: Procedures for Employee Injuries On-the-Job
Effective Date: June 22, 1988	Revision Date: September 10, 2007
Approved by: K T KENNETH T. TAGAWA, General Manager	

I. **PURPOSE:** To establish procedures for reporting of employee injuries on-the-job.

II. **DISCUSSION:** The foundation for an effective safety program must be built upon solid facts—about accidents. Unless we have a good reporting system to record every mishap, we would be lost when it comes to correcting hazards and—most important of all—attitudes. A written report of each accident occurring on the job is important for three reasons:

- (1) to locate the cause of the injury and to prevent a similar injury.
- (2) to help us determine how long the employee is likely to be out of work and how his injury will affect his future performance and its impact on the operational efficiency of the division and the Port.
- (3) to provide information to protect the interests of both the employee and the Port in case of compensation and other claims.

Every accident report must cover who is injured where it took place...what caused it...which area of the body is involved and how serious the injury is. Regardless of the nature of severity, all injuries incurred while on-the-job must be reported immediately, during the same shift in which the injury occurred.

III. **RESPONSIBILITIES**

- A. An employee claiming injury while on duty must immediately report the injury to his supervisor. If the supervisor is not available, the employee shall report the injury to the Port's safety personnel or any available management official within the Port.

- B. The **supervisor, on-duty safety personnel or management official**, shall complete Form GWC-101a/b, "Authorization for Medical Examination" which must be accompanied with the employee in order for him to receive treatment with Guam Memorial Hospital. The attending physician must complete Form GWC-101b and mail such form to Workers' Compensation Commission and the Port.
- C. The **supervisor, on-duty safety personnel or management official** shall also complete Form GWC-201, "Notice of Employee's Injury, Illness or Death" and submit such form to the Safety Administrator, who will transmit copies of the form to Workers' Compensation Commission and Port's Human Resources Office.
- D. The **Safety Administrator or his designee** shall complete the following forms and transmit it to Workers' Compensation Commission:
 - (1) Form GWC-202, "Employer's Report of Occupational Injury or Illness".
 - (2) If Form GWC-202 does not indicate a date when the employee returned to work or each time an injured employee has returned to work but later becomes disabled, Form GWC-210, "Employer's Supplemental Report of Accident or Occupational Illness" shall be completed.
- E. Copies of Forms GWC-101a/b, 201, 202 and 210 shall be filed in the employee's medical file, located in the Port's Human Resources Office.
- F. In case of serious injury, the employee shall be immediately sent to Guam Memorial Hospital. If necessary, an ambulance should be called to transport the employee. Prompt notification of the employee's family must be made by the supervisor.

IV. POST-INJURY TREATMENT

- A. If it becomes necessary for the employee to seek post-injury treatment with his personal physician or referred to seek treatment with a specialized physician, the employee must obtain another referral form from the Occupational Safety & Health Division. The form to be used is GWC101a/b.
- B. Failure to do so may result in the Port denying such services if medical billing is received.

IV. PAYMENT OF INJURY INVOICES

It shall be the responsibility of the:

- a. Safety Administrator to review all invoices arising out of work related injuries submitted by Workers' Compensation Commission and/or by referred physicians.
- b. Finance Division to issue payments to Workers' Compensation Commission on a timely basis.

Attachments:

1. Form GWC 101a/b - Authorization for Medical Examination
2. Form GWC 201 - Notice of Employee's Injury, Illness or Death
3. Form GWC 202 - Employer's Report of Occupational Injury or Illness
4. Form GWC 210 - Employer's Supplemental Report Accident or Occupational Illness

WORKER'S COMPENSATION COMMISSION
Department of Labor * Government of Guam * P.O. Box 9970 Tamuning, Guam 96931
 Tel: (671) 475-7033/4 * Fax: (671) 475-7026

WCC File#

INSTRUCTIONS: This side of the form should be completed in full. It authorizes a physician (duly qualified physicians include surgeons, osteopathic acupuncturists within the scope of their practice as defined by law) to examine and/or treat the employee for the injuries arising out of such accidental occupational injury, illness, or disease covered by the Guam Worker's Compensation Law. PLEASE TYPE OR PRINT LEGIBLY.		
1. Name of Authorized Physician:	2. Name of Medical Facility:	
3. Physician's Address:	4. Medical Facility's Address:	
5. Name of Injured Employee, DoB, & SSN:	6. Occupation:	7. Date of Injury:
8. Description of Injury:		
9. YOU ARE AUTHORIZED TO PROVIDE MEDICAL SERVICES TO THE EMPLOYEE AS FOLLOWS: (Please check one)		
	A) If you believe the condition is related to the injury, furnish office and/or hospital treatment as necessary for the effects of the injury.	
	B) If there is doubt as to whether the condition is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in Item 14 whether you believe the disability is due to the alleged injury. Pending further advice, you may provide such necessary conservative treatment.	
	C) Other:	
YOU ARE REQUESTED TO SUBMIT A WRITTEN REPORT OF FIRST TREATMENT WITHIN 20 DAYS TO THE COMMISSIONER AT THE ADDRESS INDICATED ITEM 13 BELOW. (See back of this form for instructions as to the medical report and the submission of your charges). Reports are requisite if services are to be paid.		
GCG 37031 PENALTY FOR MISREPRESENTATION: "Any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this Title or for the purpose of evading liability for any benefit or payment under this Title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine not to exceed one thousand dollars (\$1,000.00), or by imprisonment not to exceed one (1) year, or both."		
10. Signature and Title of Authorizing Official:	11. Name and Address of Employer:	
12. Date:		
13. Send your REPORT to:	14. Name & address of Insurance Carrier to whom COPY of your report and BILL are to be sent:	
WORKER'S COMPENSATION COMMISSION P.O. Box 9970 Tamuning, Guam 96931	Same as Item # 13 unless otherwise specified	
FOR STATISTICAL PURPOSES ONLY:		
Employee's ethnicity (please choose one):		Employee's citizenship (please choose one):
Yapese Pohnpeian American Korean Chuukese Marshalls Pacific Islander Chinese Kosraean Palauan Filipino Japanese Other (specify):		U.S. Permanent Alien Resident Other (specify):

ATTENDING PHYSICIAN'S REPORT OF INJURY AND TREATMENT

INSTRUCTIONS TO PHYSICIAN: This initial report should be completed and mailed within 20 days, the original to the Commissioner (see item 13 for address), with a copy to the Company in item 14. Subsequent reports should be made regularly on Form GWC-204 or in narrative form while employee is in your care. Please read Item 9 on the front of this form. PLEASE TYPE OR PRINT LEGIBLY.

15. What history of injury or disease did Employee give to you?

16. Is there any history or evidence of PRE-EXISTING injury, disease, or physical impairment? ☐ NO ☐ YES (Describe):

17. What are your findings?

18. What is your diagnosis?

19. Do you believe the condition found was CAUSED or AGGRAVATED by the employment activity described? ☐ YES ☐ NO
(Please explain if there is doubt):

20. Did injury require hospitalization? ☐ YES ☐ NO
Hospital:
Admission date:
Discharge date:

21. Is additional hospitalization required? ☐ YES ☐ NO

22. Surgery (If any, please describe):

Date performed:

23. Other types of treatments:

24. What PERMANENT DEFECTS do you anticipate?

25. Date of first examination:

26. Dates of treatments:

27. Date of discharge:

28. Period of TEMPORARY DISABILITY
(Indicate if unknown):

Partial Disability: From To
Total Disability: From To

29. Date Employee was able to resume work:

LIGHT WORK ☐
REGULAR WORK ☐

30. If Employee is able to resume work, date when advised:

31. If Employee is able to resume only light work, indicate extent of PHYSICAL LIMITATIONS and type of work he could reasonably perform with limitations:

32. General remarks and RECOMMENDATIONS for future care, if indicated:

33. Do you SPECIALIZE? ☐ NO ☐ YES. (Please specify):

GCS 37031 PENALTY FOR MISREPRESENTATION: "Any person who wilfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this Title or for the purpose of evading liability for any benefit or payment under this Title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine not to exceed one thousand dollars (\$1,000.00), or by imprisonment not to exceed one (1) year, or both."

34. Name & Signature of Physician:

35. Address:

36. Date of report:

37. MEDICAL BILL (Charges for your services may be presented in the space below or on your billhead).

Date/Period of treatment(s)	Service/Supplies (MUST be itemized)	Quantity	Unit Price	Amount

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam

P. O. Box 9970 Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File #:

INSTRUCTIONS: This form may be used by the Employee to file a NOTICE of an injury, illness or in the case of death, by Employee's representative. No benefits need be paid without this notice. Notice shall be given to the Commissioner and to the Employer by delivery or to the last known place of business. 22 GCA 9113. PLEASE PRINT OR TYPE.

THIS IS NOT A CLAIM

1. Name of injured Employee, DOB, & SSN: - - -	2. Name of Employer & EIN:
3. Employee's address & telephone no: ()	4. Employer's address:
5. Date & time of alleged injury/illness:	6. Did employee stop work? If so, date stopped:
7. Employee's occupation:	8. Name of supervisor at time of injury:
9. Place where injury occurred:	
10. Is another person not of your employment the cause of the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. Will you file suit against the other person? <input type="checkbox"/> YES <input type="checkbox"/> NO
12. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED: Relate the events which resulted in the injury/illness. Tell what the Employee was doing at the time of the accident. Tell what happened and how it happened. Name any object or substance involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. Use additional sheets if required and attach to this report.	
13. Effects of the injury (Indicate parts of body affected and how affected).	
22 GCA 9132 PENALTY FOR MISREPRESENTATION: "Any person who wilfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this Title or for the purpose of evading liability for any benefit or payment under this Title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine not to exceed one thousand dollars (\$1,000.00), or by imprisonment not to exceed one (1) year, or both."	
14. Name & signature of person completing this notice:	15. Date of this notice:
FOR STATISTICAL PURPOSES ONLY	
Please choose ONE ETHNICITY:	Please choose ONE CITIZENSHIP:
Yapese Chuukese Kosraean Pohnpeian Chinese Marshallese Palauan Guamanian Filipino Other (specify): American African American Japanese Korean	United States Permanent Resident Alien Other (specify):

Department of Labor * Government of Guam
P.O. Box 9970, Tamuning, Guam 96931
Tel: (671) 475-7033/34 * Fax: (671) 475-7026

INSTRUCTIONS: This form may be used by the Employer to report an injury or illness. 22 GSA 9131 requires the Employer to report to the Commissioner within ten (10) days from the date of or knowledge of any injury or illness. Failure or refusal to file this report may subject the Employer to a penalty of up to \$500.00. PLEASE PRINT OR TYPE.

Form GWC-202: EMPLOYER'S REPORT of OCCUPATIONAL INJURY or ILLNESS (Revised 01/2005)

PLEASE CIRCLE THE APPROPRIATE ITEMS (for statistical purposes)

A. EVENT CODE

01 Fatality	02 No Time Loss	03 Time Loss
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B. NATURE OF INJURY CODE

01 Amputation	08 Disease/Illness	15 Hearing Loss
02 Asphyxia	09 Dislocation	16 Hernia
03 Bruise/Contusion/Abrasion	10 Electric Shock	17 Poisoning (Systemic)
04 Burn (Chemical)	11 Exertion	18 Puncture
05 Burn (Heat)	12 Foreign Body in Eye/Conjunctivitis	19 Radiation Effects
06 Concussion	13 Fracture	20 Strain/Sprain
07 Cut/Laceration/Puncture	14 Freezing/Frostbite	21 Other (Specify)

C. BODY PART CODE LEFT | RIGHT

Abdomen	01		Thumb	14	15	Great Toe	34	35
Ankle(s):	02	03	Fingers Index-Small			Toes		
Back	04		(First-Fourth)	16 17 18 19	20 21 22 23	(First-Fourth)	36 37 38 39	40 41 42 43
Body	05							
System	06		Wrist	24	25	Ankle	44	45
Chest	07		Hand	26	27	Foot	46	47
Head	08		Elbow	28	29	Knee	48	49
Ear(s)	09	10	Arm	30	31	Leg	50	51
Eye(s)	11	12	Shoulder	32	33	Hip(s)	52	53
Face	13							

D. TYPE OF EVENT CODE

01 Absorption	05 Fall (Same level)	10 Rubbed/Abraded
02 Bite/Sting/Scratch	06 Fall (From elevation)	11 Shock
03 Cardio-Vascular/Respiratory	07 Ingestion	12 Struck Against
System Failure	08 Inhalation	13 Struck By
04 Caught In or Between	09 Repeated Motion/Pressure	14 Other (Specify)

E. SOURCE INJURY CODE

01 Aircraft	15 Electrical Apparatus/Wiring	29 Metal Products
02 Air Pressure	16 Explosives	30 Motor Vehicle (Highway)
03 Animal/Insect/Bird/Reptile/Fish	17 Fire/Smoke	31 Motor Vehicle (Industrial)
04 Boat	18 Food	32 Motorcycle
05 Bodily Motion	19 Furniture/Furnishings	33 Person
06 Boiler/Pressure Vessel	20 Gases	34 Petroleum Products
07 Boxes/Barrels, Etc.	21 Glass	35 Pump/Prime Motor
08 Buildings/Structures	22 Hand Tool (Manual)	36 Radiation
09 Chemical Liquid/Vapor	23 Hand Tool (Powered)	37 Vegetation
10 Cleaning Compound	24 Heat (Environmental/Mechanical)	38 Waste Products
11 Cold (Environment/Mechanical)	25 Hoisting Apparatus	39 Water
12 Dirt/Sand/Stone	26 Ladder	40 Weapons
13 Drugs/Alcohol	27 Machine	41 Working Surface
14 Dust/Particles/Chips	28 Materials Handling Equipment	42 Other (Specify)

F. CONTRIBUTING ENVIRONMENTAL FACTOR CODE

01 Catch Point/Pointer Action	10 Pinch Point Action
02 Chemical Action/Reaction Exposure	11 Radiation Condition
03 Flammable Liquid/Solid Exposure	12 Shear Point Action
04 Flying Object Motion	13 Sound Level
05 Gas/Vapor/Mist/Fume/Smoke/Dust Condition	14 Squeeze Point Action
06 Illumination	15 Temperature Above or Below Tolerance Level
07 Materials Handling Equipment/Method	16 Weather/Earthquake, Etc. Condition
08 Overhead Moving and/or Falling Object Action	17 Working Surface/Facility Layout Condition
09 Overpressure/Underpressure Condition	18 Other (Specify)

G. TASK ASSIGNMENT CODE

01 Employee Working at Regularly Assigned Task(s)	02 Employee Working at OTHER than Regularly Assigned Task(s)
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P.O. Box 9970 Tamuning, Guam 96931
Tel.: (671) 475-7033/34 * Fax: (671) 475-7026

WCC File #:

INSTRUCTIONS: This report must be filed promptly with the Commissioner in every case in which (1) Form GWC-202 does not show the date employee returned to work, and (2) each time an injured employee has returned to work but later becomes disabled for work. If the employee is medically certified disabled for work, compensation payments should be reported on Forms GWC-206 and/or GWC-208. Medical reports must be sent to the Commissioner promptly following first treatment and thereafter while treatment continues.

1. Employee's name, mailing address, DOB, & SSN: - - -	2. Name and address of your insurance carrier:
Home phone: () Work phone: ()	

3. Date of initial injury/illness:	4. Date of initial disability:	5. Date of initial return to work:
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6. Is Employee receiving pre-injury wages? [] YES [] NO	7. Employee's pre-injury regular wages:
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8. If this report covers a period of disability after the date shown in Item 5, state each subsequent period of disability. Use inclusive dates for (a) and (b).

(a) From	(b) To	(c) Date of return to work	(d) Wages received

9. Did Employee receive medical attention?

- [] YES - List dates, names and addresses of physicians and hospitals providing treatments.
[] NO - Explain.

10. Name address of Employer:	11. Date insurance carrier provided copy of report:
	12. Name and signature of person making report:
	13. Title of person making report:
	14. Date of this report:

*** FOR STATISTICAL PURPOSES ONLY ***

Please choose one ETHNICITY:	Please choose one CITIZENSHIP:
Yapese American Chamorro Chuukes African American Filipino Kosraean Korean Chinese Pohnpeian Other (specify):	United States Permanent Resident Alien Other (specify):