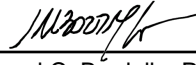
 <p>GUAM WATERWORKS AUTHORITY</p>	STANDARD OPERATING PROCEDURE	No.	SOP-1300-SAF-005
	Workers' Compensation	Effective Date	6/22/2026
		Final Approver	 Miguel C. Bórdallo, P.E. General Manager
		Revision Letter	A

1.0 Purpose

This Standard Operating Procedure (SOP) outlines the steps for handling work-related injuries or illnesses, ensuring employees receive proper medical care and benefits while complying with legal requirements.

2.0 Scope

This SOP applies to all Guam Waterworks Authority (GWA) employees.

3.0 Policy

GWA is committed to providing a safe workplace and benefits for employees that may become injured or ill as a result of conducting work for GWA.

This SOP is established in accordance with the requirements of the Code of Federal Regulations (CFR) 1910, General Duty Clause Section 5(a)(1) of the Occupational Safety and Health Act of 1970 (OSHA).

4.0 Definitions

- 4.1. **Consent or Waiver for Medical Attention:** This form is for the employee to fill out and sign at the time of reporting an injury to inform GWA that they either are in need of medical attention or no medical attention is needed at the time of the incident.
- 4.2. **Employee:** An individual currently employed with GWA.
- 4.3. **ESS Report an Incident:** Digital incident reporting tool under JD Edwards EnterpriseOne (E1) used by GWA employees.
- 4.4. **Form GWC-101a – Authorization for Medical Examination and/or Treatment:** Form used to authorize a single visit to the Emergency Room.
- 4.5. **Form GWC-101b – Attending Physician’s Report of Injury and Treatment:** Form for Doctor to fill out and to give further instruction.
- 4.6. **Form GWC-201 - Notice of Employee’s Injury/Illness or Death:** Form to be filled out by the employee; if the employee is unable to complete, a third party may assist.
- 4.7. **Form GWC-202 - Employer’s Report of Occupational Injury or Illness:** Form to be completed by a supervisor, manager, or the Safety Inspector.
- 4.8. **Illness:** A health condition that an employee develops as a direct result of his/her job duties or workplace environment.
- 4.9. **Injury:** Any injury sustained by an employee as a direct result of his/her job duties.

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- 4.10. **Lost Work Days:** Refers to the period of time an employee is unable to work due to a work-related injury or illness and are eligible to receive wage replacement benefits.
- 4.11. **Restricted Work Days:** Refers to a period where an employee, due to a work-related injury or illness, is allowed to work but with limitations or modifications to their job duties. This involves a doctor recommending restrictions and GWA providing modified or light-duty work that complies with the doctor-recommended restrictions.
- 4.12. **Workers' Compensation (WC):** A type of insurance that provides benefits to employees who are injured or become ill during the course of conducting job-related work while on GWA's work schedule.

5.0 Roles and Responsibilities

5.1.	General Manager (GM)	Approves this SOP and all its subsequent changes.
5.2.	Assistant General Manager for Compliance & Safety (AGM-CS)	Oversees the development, revision, and implementation of this SOP as the Policy Owner.
5.3.	Safety Inspector Supervisor	<p>Reviews this SOP annually and makes necessary changes to be presented to the AGM-CS for consideration.</p> <p>Ensures that proper training and/or training guidelines are provided to the affected employees every two (2) years to ensure proper compliance with this SOP.</p> <p>Reviews the official investigation report prepared by the Safety Office.</p>
5.4.	Safety Office	<p>Investigates all workplace injuries and illnesses.</p> <p>Responsible for the filing of relative documents arising from the injured personnel case and monitoring of the injured employee.</p> <p>Assists with delivering documents to the WC Office if the employee is unable to do so.</p> <p>Responsible for ensuring the employee returns to work.</p> <p>Prepares the official investigation report within five (5) days following the incident.</p>
5.5.	Personnel Services Administrator (PSA)	Ensures training and recordkeeping are upheld.

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6.0 Procedure Description

- 6.1. **Employee's Responsibilities:** It is required by law that all injuries/illnesses be reported. Failure to report an injury or illness may result in the loss of benefits.
 - 6.1.1. Any and all injuries/illnesses must be reported immediately to the employee's immediate supervisor/manager and the GWA Safety Office.
 - 6.1.2. If the employee is just reporting an injury/illness and is not in need of medical attention, he/she must:
 - 6.1.2.1. Complete *Form GWC-201 Employee's Notice of Injury/Illness or Death (Attachment 1)* and submit it to the GWA Safety Office.
 - 6.1.2.2. Complete a *Consent or Waiver for Medical Attention (Attachment 2)*.
 - 6.1.2.3. Complete an incident report. Refer to Section 6.3 for complete procedures.
 - 6.1.3. If the injury/illness requires immediate attention:
 - 6.1.3.1. *Forms GWC-201 (Attachment 1), GWC-202 (Attachment 3), and GWC-101a (Attachment 4)* may be filled out by either the GWA Safety Office or the employee's direct supervisor or manager.
 - 6.1.3.1.1. *Form GWC-101a (Attachment 4)* must be completed before the employee is escorted to the emergency room at Guam Memorial Hospital (GMH), or if directed at Guam Regional Medical City (GRMC), pursuant to 22 GCA Section 9108(e). *Form GWC-101b (Attachment 5)* shall be attached to *GWC-101a* to be completed by the attending physician.
 - 6.1.4. All documents must be delivered to the Workers' Compensation (WC) Office within the next 24 hours.
 - 6.1.4.1. The employee will need to turn in the original documents to the WC Office and return the stamped received copies to the GWA Safety Office.
 - 6.1.4.1.1. If the employee is unable to deliver documents to the WC Office, the GWA Safety Office will assist.
 - 6.1.4.2. The employee will receive a copy for his/her records from the GWA Safety Office.
 - 6.1.5. For injuries/illnesses that require follow-up:
 - 6.1.5.1. If the employee is advised to have a follow-up appointment, only the WC Office can authorize such.
 - 6.1.5.2. Any follow-up documentation - including but not limited to a new *GWC-101a (Attachment 4)*, doctor's appointments, physical therapy, or doctor's excuse notes - must be submitted immediately to the GWA Safety Office for filing and distribution to appropriate personnel responsible for managing the injury or illness.

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- 6.1.6. When returning to work, submit all doctor's notes to the GWA Safety Office immediately.
 - 6.1.6.1. If an employee is returning to work from an injury/illness, the doctor's note will indicate when the employee may return.
 - 6.1.6.2. If it is a "restricted duty" return, the GWA Safety Office will review the doctor's note and confer with doctor (if necessary), and advise the employee of the meaning of the note. The employee must abide by all restrictions and will be monitored to ensure that he/she remains in compliance with said restrictions.
 - 6.1.6.3. If the employee is cleared to full duty without restrictions, the GWA Safety Office will review and advise all who are required to be notified of the clearance.

6.2. **Managers and Supervisors are additionally responsible for:**

- 6.2.1. Immediately assessing the injury/illness and determining if an ambulance is required.
- 6.2.2. Immediately reporting and conferring with the Safety Office on the GWA Drug and Alcohol-Free Workplace Policy (DAFWP)¹.
- 6.2.3. If employee declines medical attention:
 - 6.2.3.1. Ensuring that the *Consent or Waiver for Medical Attention Form (Attachment 2)* and *Form GWC-201 (Attachment 1)* are filled out and signed by the employee immediately.
 - 6.2.3.2. Documenting the refusal by filling out *GWC-202 form (Attachment 3)*.
- 6.2.4. Assisting with the process, if the employee is unable to fill out *Form GWC-201 (Attachment 1)*, and preparing *Forms GWC-101a (Attachment 4)* and *GWC-202 (Attachment 3)*.

As stated in Section 6.1.3.1.1, *Form GWC-101a* must be completed before the employee is escorted to the emergency room and *Form GWC-101b* must be attached to *101a*. Refer to the section for complete procedures.

- 6.2.5. Escorting employee to the emergency room: The supervisor/manager is required to remain at the hospital unless relieved by either another GWA employee or a family member.

At times, GMH and GRMC will have protocols in place that prohibit individuals from remaining at the hospital while an employee is receiving medical treatment. Under these circumstances, the supervisor or manager may depart and return upon the employee's discharge to transport the employee back to the worksite unless a family member is present to transport the employee.

¹ SOP-1200-HR-001 Drug and Alcohol-Free Workplace Policy

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- 6.2.6. Ensuring that all documents are accounted for and that the employee or the GWA Safety Office submits them to the WC Office in Hagåtña and to the GWA Safety Office within 24 hours.
- 6.2.7. Ensuring that all restrictions (if any) are followed upon the employee's return to work status.

6.3. Reporting:

- 6.3.1. The employee shall contact the GWA Safety Office at any of the following numbers and notify his/her supervisor immediately. Additional contact information is included in **Attachment 6**.

GWA Safety Office Contact Information		
Safety Inspector Supervisor	Safety Inspector	Safety Inspector
Office: (671) 300-6349	Office: (671) 300-6358	Office: (671) 300-6340 ext. 6386

- 6.3.2. There may be occasions where, under emergency circumstances, immediate action or attention is required before contacting the GWA Safety Office.
 - 6.3.3. Submit an incident report through the ESS 'Report an Incident' tool, if accessible, or fill out the *Incident Report – Witness Form (Attachment 7)* and submit it to the GWA Safety Office within 24 hours after the incident occurred. If the employee is unable to submit through ESS 'Report an Incident', management or Safety will submit.
- 6.4. Investigation:** The GWA Safety Office is responsible for conducting a thorough investigation and reporting all incidents. Reporting shall include the initial assessment, immediate actions taken, interviews, and any other fact-finding information.
- 6.4.1. The GWA Safety Office prepares the official investigation report to be reviewed by the Safety Inspector Supervisor within five (5) days following the incident.
 - 6.4.2. Immediately after being notified, the Safety Inspector shall communicate with the Supervisor reporting the event to determine if there are grounds for a drug and alcohol test as described on the GWA DAFWP.
 - 6.4.3. In the event the incident was caused by an individual not employed by GWA, the GWA Safety Office will work with the Guam Police Department to resolve.
 - 6.4.4. Once reviewed, the Safety Inspector Supervisor submits the official investigation report to the Executive Management team of which the employee reports, the Personnel Services Administrator (PSA), with the Employee Management Relations (EMR) Section copied, and to the Administration support of the employee's section.
 - 6.4.5. In the event the employee is subjected to time off work, the GWA Safety Office will share documents pertaining to the loss time to the GWA Payroll Office for accurate accounting of time off.
- 6.5. Management of Workers' Compensation Case:** The GWA Safety Office will manage all relative documents arising from the injured personnel case.

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- 6.5.1. Upon receipt of any follow-up doctor's note, the GWA Safety Office will produce an email with copies of the note and distribute accordingly.
- 6.5.2. When the employee has been cleared to return to work, the GWA Safety Office will generate a "Return to Work" document (**Attachment 8**) to include whether it is with restrictions or back to full duty, and distribute accordingly.
- 6.6. **Confidentiality:** Documents are only shared with the departments in GWA that are pertinent to the management of these claims.
- 6.7. **Mandatory Training:** The HR's Training and Development section shall coordinate with the Safety Inspector Supervisor to develop and/or update the training programs every two (2) years, including but not limited to tracking compliance and non-compliance to this SOP. All employees must receive training and sign the *Acknowledgment Receipt* (**Attachment 9**) to confirm their understanding and compliance with the procedures outlined in the SOP. Training for new employees shall be included as part of their on-boarding.
- 6.8. **Non-Compliance with this SOP:**
 - 6.8.1. **Employees:** Failure of the employee to adhere and comply with any of the guidelines, policies, and procedures stated herein may result in progressive or adverse disciplinary action, including but not limited to suspension, demotion or termination of employment as provided by GWA Personnel Rules and Regulations (PR&R).
 - 6.8.2. **Supervisors and Managers:** Failure of the Manager or Supervisor to report and enforce all the guidelines, policies, and procedures stated herein may result in progressive or adverse disciplinary action, including but not limited to suspension, demotion, or termination of employment as provided by GWA PR&R.

7.0 Document Approvals

Role	Position	Name of Approver	Approval Signature	Date Approved
Author	Management Analyst IV & Safety Inspector Supervisor	Kathleen B. Beleno & Wade T. Tenorio	Approval on File	On File
Policy Owner	Assistant General Manager for Compliance & Safety (AGM-CS)	Paul J. Kemp, M.S.	Approval on File	On File
Final Approver	General Manager	Miguel C. Bordallo, P.E.	Page 1	Page 1

By existing Guam and federal laws, the contents of this SOP were reviewed thoroughly by its policy owner and were found to be:

- appropriate for publication on the GWA website without compromising the security of GWA's system or the public's health and safety.
- not appropriate for publication on the GWA website because it might jeopardize the security of GWA's system or the public's health and safety.

8.0 Records of Revisions

All suggestions for improvement shall be directed to the policy owner indicated below. The policy owner will consider the input received, develop recommendations on how to address the

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suggestions and obtain authorization to make the recommended changes. Updates, revisions, corrections, and waivers to this SOP shall be made in writing, and be approved by the GM.

8.1. Policy Owner: Assistant General Manager – Compliance & Safety (AGM-CS)

8.2. Authorization: General Manager (GM)

Effective Date	Revision Letter	Document Author	Description of Change
Page 1	A	Kathleen B. Beleno & Wade Tenorio	Initial Release of Policy/Procedure

9.0 References

- 9.1. U.S. Department of Labor website OSH Act of 1970 | Occupational Safety and Health Administration
- 9.2. Department of Labor's Workers' Compensation [website](#)
- 9.3. SOP-1200-HR-001 Drug and Alcohol-Free Workplace Policy

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Attachment 1: Form GWC-201 Notice of Employee's Injury/Illness or Death

WORKER'S COMPENSATION COMMISSION

Department of Labor * Government of Guam

P. O. Box 9970 Tamuning, Guam 96931
Tel: (671) 300-4571/77 Fax: 671-475-6811

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 "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."	
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	Marshallese	American	United States	
Chuukese	Palauan	African American	Permanent Resident Alien	
Kosraean	Guamanian	Japanese	Other (specify):	
Pohnpeian	Filipino	Korean		
Chinese	Other (specify):			

Form GWC-201: NOTICE of EMPLOYEE'S INJURY/ILLNESS or DEATH (Revised 3/2014)

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Attachment 2: Consent or Waiver for Medical Attention



Suite 200, Gloria B. Nelson Public Service Building
688 Route 15
Mangilao, Guam 96913
GWASafety@guamwaterworks.org
Telephone: (671) 300-6349

**WORKERS' COMPENSATION
CONSENT OR WAIVER FOR
MEDICAL ATTENTION**

A.

1. I, _____ voluntarily accept the need for medical attention.
2. I hereby acknowledge that I was injured during working hours and will be following the Workers' Compensation policies.
3. I voluntarily choose to receive medical attention. I understand that receipt of medical attention is not a condition of employment, and I am free to refuse medical attention or accept it, and it will in no way affect my job. I have read and understand all information presented to me and accept responsibility for any risk or reactions associated with receiving medical attention. I hereby release Guam Waterworks Authority (GWA) and the medical provider from all liability and claims for damage and reason of any injury whatsoever from any cause or causes is anyway connected with the administration of the medical attention.

OR

B.

1. I, _____ hereby waive the opportunity and refuse to accept the medical attention. I am fully aware that by this waiver, I accept responsibility for all consequences of this decision and herewith hold harmless GWA as an entity, the CCU or any employees of these, from any problem that may result from this decision.
2. I understand that I may change my decision and request medical attention if I feel that it is necessary. Even if I do seek medical care within a 12 months of the incident as described on Guam Code Title 22 § 9114(a), I understand that I will continue to hold GWA, the CCU, and all GWA employees harmless for any physical, medical, or monetary consequence that may result from my decision to seek medical care at a later date.

Employee Signature

Date

Witness Signature

Date

Employee Position Title

Date

Department

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Attachment 3: Form GWC-202 - Employer's Report of Occupational Injury or Illness

WORKER'S COMPENSATION COMMISSION Department of Labor * Government of Guam P.O. Box 9970, Tamuning, Guam 96931 Tel: (671) 300-4571/77 Fax: (671) 475-6811			
WCC File #:			
INSTRUCTIONS: This form may be used by the Employer to report an injury or illness. 22 GCA 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.			
1. Name of injured Employee, DOB & SSN:		2. Name of Employer & EIN:	
3. Employee's address & telephone no.: ()		4. Employer's address & Telephone no.: ()	
5. Date & time of alleged injury/illness:		6. Date of Employer's first knowledge of injury:	
7. Date & hour Employee first lost time because of injury/illness:		8. Date & hour Employee returned to work:	
9. Date & hour pay stopped:		10. Days usually worked per week (x days): S M T W TH F S Average hours per week:	
11. Employee's occupation:		12. Employee's wages/earnings (overtime, etc):	
13. Is another person not of your employment caused the accident? <input type="checkbox"/> YES <input type="checkbox"/> NO		a. Hourly: \$ _____ b. Weekly: \$ _____	
14. DESCRIBE IN FULL HOW THE ACCIDENT OCCURRED: Relate the events which resulted in the injury/illness. Tell what the injured 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.			
15. NATURE OF INJURY/ILLNESS (Name part of body affected - fractured leg, bruised arm, lacerated finger, etc) Note any amputations.			
16. Has medical attention been authorized? <input type="checkbox"/> YES <input type="checkbox"/> NO	17. Date authorized:	18. Has insurance carrier been notified? <input type="checkbox"/> YES <input type="checkbox"/> NO	19. Date notified:
20. Name of treating physician:		21. Name of insurance carrier: Worker's Compensation Commission c/o Guam Dept of Labor	
22. Name of treating facility:		23. Name & signature of person completing report:	
22 GCA §9132 "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."			
24. Title of person completing report:		25. Date of this report:	
FOR STATISTICAL PURPOSES ONLY			
Please choose ONE ETHNICITY:			Please choose ONE CITIZENSHIP:
Yapese	Marshallese	African American	United States
Chuukese	Palauan	Japanese	Permanent Resident Alien
Kosraean	Chamorro	Chinese	Other (specify):
Pohnepian	Filipino	American	
Korean	Other (specify):		

Form GWC-202: EMPLOYER'S REPORT of OCCUPATIONAL INJURY or ILLNESS (Rev 3/1/2014)

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Attachment 3: Form GWC-202 - Employer's Report of Occupational Injury or Illness (cont'd)

PLEASE CIRCLE THE APPROPRIATE ITEMS (for statistical purposes)									
A. EVENT CODE									
01 Fatality			02 No Time Loss				03 Time Loss		
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 System	05		Wrist	24	25	Ankle	44	45	
Chest	06		Hand	26	27	Foot	46	47	
Head	07		Elbow	28	29	Knee	48	49	
Ear(s)	08	10	Arm	30	31	Leg	50	51	
Eye(s)	09	12	Shoulder	32	33	Hip(s)	52	53	
Face	11								
	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 System Failure			07 Ingestion			12 Struck Against			
04 Caught In or Between			08 Inhalation			13 Struck By			
			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			29 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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Attachment 4: Form GWC-101a – Authorization for Medical Examination and/or Treatment

WORKERS' COMPENSATION COMMISSION		
Department of Labor * Government of Guam * P.O. Box 9970 Tamuning, Guam 96931		
Tel: (671) 922-2550/2553/2555/2577		
WCC File#		
<p>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.</p>		
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.	
xxxxxxxxxxxxxx	C) Other:	
<p>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 <u>are</u> requisite if services are to be paid.</p>		
<p>22 GCA §9132 "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."</p>		
10. Signature and Title of Authorizing Official: JOANNALYNN FULLERTON, WCC ADMINISTRATOR	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	See Box 13	
FOR STATISTICAL PURPOSES ONLY:		
Employee's ethnicity (please choose one):	Employee's citizenship (please choose one):	
Yapese Pohnpelan American Korean Chuukese Marshalls Pacific Islander Chinese Kosraean Palauan Filipino Japanese Other (specify):	U.S. Permanent Alien Resident Other (specify):	
FORM GWC-101a: AUTHORIZATION for MEDICAL EXAMINATION and/or TREATMENT (Revised 10/2025)		

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Attachment 5: Form GWC-101b – Attending Physician’s Report of Injury and Treatment

ATTENDING PHYSICIAN'S REPORT OF INJURY AND TREATMENT				
INSTRUCTIONS TO PHYSICIAN: This initial report should <u>be completed and mailed within 20 days</u> , 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? <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO (Please explain if there is doubt):				
20. Did injury require hospitalization? <input type="checkbox"/> YES <input type="checkbox"/> NO Hospital: _____ Admission date: _____ Discharge date: _____		21. Is additional hospitalization required? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> REGULAR WORK <input type="checkbox"/>		
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? <input type="checkbox"/> NO <input type="checkbox"/> YES (Please specify):				
22 GCA §9132 "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."				
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

Form GWC-101b Revised 10/2025)

Workers' Compensation

Attachment 6: GWA Safety Office's Additional Contact Information

Safety Team			
Name	Email address	Desk	Cell
Wade Tenorio	wtenorio@guamwaterworks.org	671-300-6349	671-727-8638
Richard Nauta	rnauta@guamwaterworks.org	671-300-6358	671-747-5852
Michael Cura II	macura2@guamwaterworks.org	671-300-6340 ext. 6386	671-682-4021

Workers' Compensation

Attachment 8: Return to Work Document



Gloria B. Nelson Public Service Building
 688 Route 15
 Mangilao, Guam 96913
GWASafety@guamwaterworks.org
 Telephone: (671) 300-6349

**WORKERS' COMPENSATION
 RETURN TO WORK DOCUMENT**

To: General Manager

From: Safety Supervisor

Subject: Medical Status – Return to Work from:

- Occupational Work Injury/Illness
- Non-Occupational Work Injury/Illness

The following employee has submitted medical documentation to the Safety Office:

Employee's Name:		Position Title:	
Immediate Supervisor		Division/Section	

The Safety Office has reviewed the employee's medical documentation and finds the following:

DISABILITY STATUS:	YES	NO
Cleared for Regular Work (Date): N/A		
Cleared for Modified or Restricted Duty: (See Instructions below)		
Medical Care Completed		
Medical Care On-Going		
Partial Disability (Dates):		
Total Disability (Dates):		

The employee's modified or restricted work as certified by his/her physician is/are:

Safety Representative: Print: _____

Signature: _____ Date: _____

Workers' Compensation

Attachment 9: Acknowledgment Receipt



Gloria B. Nelson Public Service Building
688 Route 15
Mangilao, Guam 96913

**WORKERS' COMPENSATION
ACKNOWLEDGMENT RECEIPT**

I, the undersigned, an employee of the Guam Waterworks Authority, hereby acknowledge receipt of SOP-1300-SAF-005 entitled "*Workers' Compensation*" on this _____ day of _____, 20____.

Employee's Name/Badge No.:	Employee's Signature:	Date:
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