Department of Commerce
WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 5795 CHRB, Saipan MP 96950
Tel: (670) 664-8018/8024 • Fax (670) 664-8074
Website: www.commerce.gov.mp

WCC FILE #: _____
CARRIER'S #: _____
EMPLOYER'S #: _____

NOTICE BY EMPLOYER TO CONTROVERT THE RIGHT TO COMPENSATION

(To Be Completed By Employer)

INSTRUCTIONS: *This form should be completed in full. The employer may controvert the right to compensation if it can show evidence that it is not liable for the payment of compensation. This notice must be filed with the Administrator before the 14th day after the employer has knowledge of the alleged injury or illness. [4 CMC 9323 (d)]*

Employer Information

1. Name of Employer:	2. Fed. ID. No.:
3. Employer's Address:	4. Date of first having knowledge of alleged injury/illness:

Employee Information

5. Name of Claimant:	6. S.S. No.:
7. Claimant's Address:	8. Claimant's Occupation:

Grounds

9. The Employer hereby states that the Claimant's right to compensation is controverted. THE EMPLOYER MUST STATE THE GROUNDS UPON WHICH THE RIGHT TO COMPENSATION IS CONTROVERTED:

(Use additional sheets if necessary and attach to this notice.)

1 0. Name and title of person completing this NOTICE:	11. Date of this NOTICE:
12. Signature:	13. Send this NOTICE to: Commisioner Workers' Compensation Commission P.O. Box 5795 CHRB Saipan, MP 96950