

First Report
of Injury or Occupational Disease
Montana Department of Labor and Industry
PO Box 8011 Helena, MT 59604-8011

Worker

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
HOME ADDRESS				CITY	STATE	POSTAL CODE	
PHONE NUMBER	EDUCATION	GENDER		MARRITAL STATUS		NUMBER OF DEPENDANTS	
	<input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR HIGH SCHOOL DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> NOT MARRIED <input type="checkbox"/> UNKNOWN				

Wages

DATE HIRED	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY		
	DATE/AMOUNT /	DATE/AMOUNT /	DATE/AMOUNT /
EMPLOYMENT STATUS	NUMBER OF DAYS WORKED PER WEEK	WAGE	<input type="checkbox"/> HOUR <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH <input type="checkbox"/> OTHER
<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER			<input type="checkbox"/> DAY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> YEAR
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED		ESTIMATED VALUE IF ANY	
<input type="checkbox"/> ROOM & BOARD <input type="checkbox"/> OVERTIME <input type="checkbox"/> BONUS <input type="checkbox"/> COMMISSIONS <input type="checkbox"/> OTHER		TIME EMPLOYEE BEGAN WORK	
WORKED NEXT SCHEDULED SHIFT	OFF WORK MORE THAN 4 WORK DAYS	DATE LAST WORKED	DATE OF RETURN TO WORK
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE		
		FULL WAGES PAID FOR DATE OF INJURY	SALARY CONTINUED
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Accident Description

JOB TITLE	DESCRIPTION OF ACCIDENT						
CAUSE OF INJURY	CAUSE CODE	PART OF BODY	PART CODE	NATURE OF INJURY	NATURE CODE	DATE OF INJURY	TIME OF INJURY
DATE DISABILITY BEGAN	DATE OF DEATH	NAMES OF WITNESSES					
		1)		2)		3)	
ACCIDENT ON EMPLOYER'S PREMISES	ACCIDENT ADDRESS OR LOCATION						
<input type="checkbox"/> YES <input type="checkbox"/> NO	CITY		STATE	POSTAL CODE			
DATE EMPLOYER NOTIFIED	ACCIDENT REPORTED TO				SAFETY EQUIPMENT PROVIDED		SAFETY EQUIPMENT USED
					<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO

Medical

ATTENDING PHYSICIAN'S NAME	ADDRESS	STATE	POSTAL CODE	PHONE NUMBER
HOSPITAL NAME	ADDRESS	STATE	POSTAL CODE	PHONE NUMBER
TYPE OF INITIAL MEDICAL TREATMENT RECEIVED <input type="checkbox"/> NO TREATMENT <input type="checkbox"/> EMERGENCY ROOM <input type="checkbox"/> TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF <input type="checkbox"/> CLINIC/DR. OFFICE <input type="checkbox"/> HOSPITAL				

Signature

“This is my claim for workers’ compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. I understand that signing this claim for compensation authorizes the release to the workers’ compensation insurer or its agent, rehabilitation records, Social Security records and health care information (medical records, pursuant to HIPAA, Public Law 104-191, 42 USC section 1301, et. seq., and section 39-71-604, MCA) that are directly relevant to the claimed injury, disease or death. I also understand that if I obtain or exert unauthorized control over workers’ compensation benefits to which I am not entitled, I may be prosecuted for theft.”

Date _____

Signature of Injured Worker or Beneficiary _____

Employer

EMPLOYER NAME	DOING BUSINESS AS	FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID)		
MAILING ADDRESS	CITY	STATE	POSTAL CODE	PHONE NUMBER
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS			NATURE OF BUSINESS SIC/NAICS CODE	SELF-INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO
EMPLOYER IS A <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> LIMITED LIABILITY COMPANY	INJURED WORKER IS A <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> LIMITED LIABILITY COMPANY <input type="checkbox"/> A MEMBER OF THE EMPLOYER'S (SOLE PROPRIETOR OR PARTNER) FAMILY LIVING IN THE EMPLOYER'S HOUSEHOLD			
DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT THIS ACCIDENT? IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE			<input type="checkbox"/> YES <input type="checkbox"/> NO	WAS WORKER INJURED WHILE IN YOUR EMPLOY <input type="checkbox"/> YES <input type="checkbox"/> NO
Prepared By	Official Title	Phone Number	Date	
PAYROLL CLASSIFICATION CODE UNDER WHICH YOU REPORT EMPLOYEE'S WAGES	AUTHORIZED EMPLOYER'S SIGNATURE _____ DATE _____			

Insurer

CLAIM ADMINISTRATOR CLAIM NUMBER	DATE REPORTED TO CLAIM ADMINISTRATOR	THE ABOVE INFORMATION IS CORRECT WITH THE FOLLOWING EXCEPTIONS <input type="checkbox"/> (ATTACH EXTRA SHEETS IF BOX AT RIGHT IS CHECKED)		
THIRD PARTY ADMINISTRATOR'S NAME	CLAIM ADMINISTRATOR ADDRESS		INSURER FEIN	
INSURER NAME	THIRD PARTY ADMINISTRATOR FEIN			
POLICY NUMBER	POLICY EFFECTIVE DATE	POLICY EXPIRATION DATE		