

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 <input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR HIGH SCHOOL DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> NOT MARRIED <input type="checkbox"/> UNKNOWN		NUMBER OF DEPENDANTS	

Wages

DATE HIRED	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT /				
EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER		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"/> DAY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> YEAR	
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED <input type="checkbox"/> ROOM & BOARD <input type="checkbox"/> OVERTIME <input type="checkbox"/> BONUS <input type="checkbox"/> COMMISSIONS <input type="checkbox"/> OTHER			ESTIMATED VALUE IF ANY	TIME EMPLOYEE BEGAN WORK	
WORKED NEXT SCHEDULED SHIFT <input type="checkbox"/> YES <input type="checkbox"/> NO	OFF WORK MORE THAN 4 WORK DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	DATE LAST WORKED	DATE OF RETURN TO WORK	FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	SALARY CONTINUED <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 <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT ADDRESS OR LOCATION CITY _____ STATE _____ POSTAL CODE _____						
DATE EMPLOYER NOTIFIED	ACCIDENT REPORTED TO			SAFETY EQUIPMENT PROVIDED <input type="checkbox"/> YES <input type="checkbox"/> NO	SAFETY EQUIPMENT USED <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."

Signature of Injured Worker or Beneficiary

Date

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				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		