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.	M.I. Date of Birth		Social Security Number	
Mailing Address					City	City State Postal Code			
Phone Number	Education	Less Than High School GED or High School Beyond High School	Diploma 🔲 I	Male 🔲 Female Unknown		rital Status Married [Widowed, Divorce Unknown	Separated ed, Single, Unmar		r of Dependants
Wages Date Hired Gross earnings for <u>four</u> pay periods preceding the injury									
Date/Amount / Date/Amount / Date/Amount / Date/Amount /									
Employment Status Number of Days worked per week Wage Wage Period								☐ Bi-Weekly	
		ed above worker received ne Bonus Comm	issions Other	ated value if					
Worked next scheduled shift					Date of Return to Work Full wages paid for date of injury Salary Continued Yes No Yes 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									
Cause of Injury	Sause Gode 11	, in the second							
Date Disability Be		Date of Death		Nam 1)	nes of Witne		2)	3)	
Accident on Employer's Premises Accident Address or Location Yes No City State Postal code									
Date Employer N	otified	Accident Reported	d to				fety Equipment I Yes 🔲 No		quipment Used s
				Medic					
Attending Physicia	an's Name	Addr	ess		State	r P	Postal Code	Phone Num	ber
Hospital Name Address State Postal Code Phone Number									
Type of initial medical treatment received No Treatment Emergency Room/Urgent Care Treatment on-site by Employer or Medical Staff Clinic/Dr. Office Hospital > 24 hours									
"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. <u>I understand</u> that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and to the Montana Uninsured Employers' Fund of: Social Security records; rehabilitation records; and all 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 of the above named worker. <u>I understand</u> that signing this claim for compensation authorized Employers' Fund of: Social Security records; rehabilitation records; and all 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 of the above named worker. <u>I understand</u> that signing this claim for compensation authorized Employers' Fund of: Social Security records; rehabilitation records; and all 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 of the above named worker. <u>I understand</u> that signing this claim for compensation authorized security records; rehabilitation records; and all 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 of the above named worker. <u>I understand</u> that signing this claim for compensation authorized security records; rehabilitation records; and all 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 claim of the control of t									
Employer Name	D	oing Business as		F			ederal Employer Identification Number (Tax I.D)		
Mailing Address		City		State	Post	tal Code	Pho	ne Number	
Location of operation, if different from mailing address						NAICS Code		Self-Insured Yes No	
Employer is a Sole Proprietorship Partnership Sole Proprietorship Sole Proprietorship Sole Proprietorship Sole Proprietorship Sole Proprietorship Corporation Limited Liability Company A member of the employer's (sole proprietor) family living in the employer's household. Do you have any reason to question this accident? Yes No Was worker injured while in your If yes, please explain fully. Use separate sheet if you need additional space Yes No									
Prepared By		Official Ti	tle		Ph	one Number	D	ate	
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 (Attach extra sheets if box at right is checked)									
Claim Administrator	r Name		Claim Admini	strator Address				Claim Administrator	FEIN
Insurer Name Insurer FEIN									
Policy Number						Policy Effective I	Date	Policy Expiration D	Pate