

First Report
of Injury and Occupational Disease
Montana Department of Labor and Industry
P.O. Box 8011 Helena, MT 59604-8011

Adjuster date Stamp

Worker

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH		SOCIAL SECURITY NUMBER	
HOME ADDRESS				CITY		STATE	POSTAL CODE	
PHONE NUMBER	EDUCATION LESS THAN HIGH SCHOOL GED OR HIGH SCHOOL DIPLOMA BEYOND HIGH SCHOOL		GENDER MALE UNKNOWN FEMALE		MARITAL STATUS MARRIED SEPARATED NOT 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 FULL TIME PART TIME SEASONAL VOLUNTEER		NUMBER OF DAYS WORKED PER WEEK	WAGE	HOUR DAY	WEEK BI-WEEKLY MONTH YEAR OTHER:
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED: BOARD & ROOM OVERTIME BONUS COMMISSIONS OTHER:			ESTIMATED VALUE IF ANY		
WORKED NEXT SCHEDULED SHIFT YES NO	OFF WORK MORE THAN 5 WORK DAYS YES NO NOT SURE	DATE LAST WORKED	DATE OF RETURN TO WORK	FULL WAGES PAID FOR DATE OF INJURY? YES NO	SALARY CONTINUED? YES NO

Accident Description

DESCRIPTION OF ACCIDENT							
CAUSE OF INJURY	CAUSE CODE	PART OF BODY	PART CODE	NATURE OF INJURY	NATURE CODE	DATE AND TIME OF INJURY /	
DATE DISABILITY BEGAN	DATE OF DEATH		NAMES OF WITNESSES:		1)	2)	3)
ACCIDENT ON EMPLOYER'S PREMISES? YES NO	ACCIDENT ADDRESS OR LOCATION CITY STATE			POSTAL CODE			
DATE EMPLOYER NOTIFIED	ACCIDENT REPORTED TO			SAFETY EQUIPMENT PROVIDED? YES NO	SAFETY EQUIPMENT USED? YES 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 NO TREATMENT EMERGENCY ROOM TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF CLINIC/DR. OFFICE HOSPITAL				

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupation disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be fined and/or imprisoned.

Signature of Injured Worker or Beneficiary: _____

Date _____

Employer

EMPLOYER NAME		DOING BUSINESS AS		FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX I.D.)	
MAILING ADDRESS:		CITY	STATE	POSTAL CODE	PHONE NUMBER
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS			NATURE OF BUSINESS OR SIC/NAICS CODE	SELF-INSURED? YES NO	
EMPLOYER IS A SOLE PROPRIETORSHIP CORPORATION	PARTNERSHIP LIMITED LIABILITY COMPANY	INJURED WORKER IS A CORPORATION	SOLE PROPRIETORSHIP LIMITED LIABILITY COMPANY	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? YES NO				IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE.	
WAS WORKER INJURED WHILE IN YOUR EMPLOY? YES NO					
PREPARED BY		OFFICIAL TITLE		DATE:	
PAYROLL CLASSIFICATION CODE UNDER WHICH YOU REPORT EMPLOYEE'S WAGES		AUTHORIZED EMPLOYER'S SIGNATURE _____ DATE _____			

Insurer

CLAIM ADMINISTRATOR'S 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 CLAIM ADMINISTRATOR'S NAME		CLAIM ADMINISTRATOR'S ADDRESS	
INSURER NAME		INSURER FEIN	
POLICY NUMBER		THIRD PARTY ADMINISTRATOR FEIN	
POLICY EFFECTIVE DATE		POLICY EXPIRATION DATE	