First Report

Adjuster date Stamp

of Injury and Occupational Disease
Montana Department of Labor and Industry
P.O. 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	Marital Status	Number of Dependents
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High Scholl	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Not ☐ Unknown	

Wages

Date Hired	Gross earnings for Four pay periods preceding the injury	Date / Amount	Date / Amount	Date / Amount	Date / Amount

Employment Status	Number of days worked per week:	Wage:
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer		☐ Hour ☐ Week ☐ month ☐ other ☐ Day ☐ BI-weekly ☐ year

In addition to Gross earnings cited above worker received: ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:
Estimated value if any:

Worked next scheduled shift	Off work more than 6 work days	Date Last Worked	Date of Return to work	Full wages paid for date of Injury?	Salary Continued?
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ yes ☐ No	☐ 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?	Accident address or location:
☐ Yes ☐ No	City: State: Postal code:

Date employer notified:	Accident Reported to:	Safety equipment provided?	Safety Equipment used?
		☐ Yes ☐ No	☐ 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 Code:	Self-Insured? ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company

Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ A member of the employer's (sole proprietor or partner) family living in the employer's household. ☐ Corporation ☐ Limited Liability Company

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: ☐ (Attach extra sheets if box at right is checked)

Third Party Claim Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:

Insurer Name:	Third Party Administrator FEIN:

Policy Number:	Policy Effective date:	Policy Expiration Date:

First Report
of Injury or Occupational Disease
Instructions

Workers' compensation insurance is a state-required insurance, which provides medical benefits, wage compensation and rehabilitation to workers injured on the job. Severe penalties can be assessed against an uninsured employer. Neither general liability nor health and accident insurance policies are substitutes for workers' compensation insurance.

The worker and employer may complete this form together, or they may each submit a separate form.

Injured Worker's Instructions

Workers have two reporting requirements: 1) notify your employer of an on-the-job injury within 30 days of its occurrence; and 2) complete this form as a claim for compensation. The form must be signed and submitted to the employer's insurer or the Department of Labor and Industry within 12 months of the accident. The form must be submitted for all injuries in order to protect your right to benefits in the event a seemingly minor injury develops into a more serious condition.

Complete a report of the injury

Be thorough in completing all areas except the gray shaded areas. It is important to you that we have complete information. Use extra sheets of paper, if needed. Type, or print with a ball point pen.

Employer's Instructions

Montana law requires employers to complete this form within six days after notice of every on-the-job injury and/or Occupational Disease (OD) by a worker.

Ensure all areas are completed except the gray shaded areas which your insurer will complete. It is important for you that we have complete information. Type, or print with a ball point pen. If you are completing with WORD software, you may tab through the fields.

If the injured worker is available to do so, they may file a claim for workers' compensation by completing and signing their portions of this form. You may then complete the employer section.

Send the original immediately to your workers' compensation insurer. If you don't know who your insurer is, contact the Montana Department of Labor and Industry (see below). SEND THIS FORM WITHIN THE 6-DAY LIMIT EVEN IF THE WORKER IS NOT AVAILABLE TO SIGN. This form must be submitted even if the employer questions whether or not the reported accident/OD is job-related. Additional sheets of paper may be attached, if needed, to fully explain all conditions concerning the accident/OD.

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office. For the employer's convenience, this form has been designed to meet such requirements and to provide employers with a copy for their records. The yellow copy is for your records.

Insurer/Adjuster (not submitting electronically)

Please complete all gray shaded areas, and mail immediately to the Montana Department of Labor and Industry at the address shown below. Boxes that have been **BOLDED** are mandatory in order to file this report. If you wish to file First Report information electronically, please contact the Employment Relations Division.

Further Information

For additional information about workers' compensation, please contact:

Workers' Compensation Claims Assistance Bureau
Employment Relations Division
Department of Labor & Industry
PO Box 8011
Helena MT 59604-8011
(406) 444-6543