Montana State Fund

OSHA Log Case #

# First Report

**Fax: 406-495-5020. Voice: 800 332-6102**
**PO Box 4759 Helena, MT 59604-4759**

Adjuster Date Stamp

## Worker

| Last Name | First Name | M.I. | Date of Birth | Social Security Number |
|---|---|---|---|---|
| | | | | |

| Mailing Address | City | State | Postal Code |
|---|---|---|---|
| | | | |

| Phone Number | Education | Gender | Marital Status | Number of Dependents |
|---|---|---|---|---|
| | ☐ Less Than High School<br>☐ GED or High School Diploma<br>☐ Beyond High School | ☐ Male ☐ Female<br>☐ Unknown | ☐ Married ☐ Separated<br>☐ Widowed, Divorced, Single, Unmarried<br>☐ Unknown | |

## Wages

| Date Hired | Gross earnings for FOUR pay periods preceding the injury<br>Date/Amount / Date/Amount / Date/Amount / Date/Amount / |
|---|---|

| Employment Status | Number of days worked per week | Wage | Wage Period |
|---|---|---|---|
| ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Piece Worker<br>☐ Volunteer ☐ Other | | | ☐ Hour ☐ Week ☐ month ☐ Day ☐ Bi-weekly |

| In addition to Gross earnings cited above worker received | Estimated value if any | Time Employee began work |
|---|---|---|
| ☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other | | |

| Worked next scheduled shift | Off work more than 4 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

| 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<br>1) 2) 3) |
|---|---|---|
| | | |

| Accident on employer's premises | Accident address or location<br>City State Postal code |
|---|---|
| ☐ Yes ☐ No | |

| 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/Urgent Care ☐ Treatment on-site by employer or medical staff ☐ Clinic/Dr. Office ☐ Hospital>24 Hours

## 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 (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. 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<br>NAICS Code | Self-Insured? ☐ Yes ☐ No |
|---|---|---|
| | | |

| Employer is a | Injured worker is a |
|---|---|
| ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company | ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ 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<br>If yes, please explain fully. Use separate sheet if you need additional space | Was worker injured while in your employ<br>☐ yes ☐ 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 ☐<br>(Attach extra sheets if box at right is checked) |
|---|---|---|
| | | |

| Claim Administrator's Name | Claim Administrator Address | Claim Administrator FEIN |
|---|---|---|
| | | |

| Insurer Name | Insurer FEIN |
|---|---|
| | |

| Policy Number | Policy Effective date | Policy Expiration Date |
|---|---|---|
| | | |