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 ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Female ☐ Unknown	☐ Married ☐ Separated ☐ Unknown ☐ Widowed, Divorced, Single, Unmarried	

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	Wage Period
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Piece Worker ☐ 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 1) 2) 3)

Accident on employer's premises	Accident address or location Address 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 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 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	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 ☐ (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