First Report

Injured Employee

Last Name*	First Name*	M.I.	Gender* ☐ Male ☐ Female ☐ Unknown	Date of Birth*	Social Security Number*

Mailing Address (including Apt/Ste/Trlr #)*

Address   City   State   Postal Code

Injured Employee's Email Address   Phone Number*

Physical Address (including Apt/Ste/Trlr #)

Address   City   State   Postal Code

Education Level
☐ Less Than High School   ☐ GED or High School Diploma   ☐ Beyond High School

Wages

Date Hired*	Date Last Worked*	Employment Status* ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other ☐ Piece Worker	Worked Next Scheduled Shift ☐ Yes ☐ No	Off Work More Than 4 Work Days ☐ Yes ☐ No	Full Wages Paid for Date of Injury ☐ Yes ☐ No	Salary Continued ☐ Yes ☐ No

Pay Frequency ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Bi-Weekly	Wage Rate	Is Sick Leave Available ☐ Yes ☐ No	Was Sick Leave Used ☐ Yes ☐ No	Returned to Work Date

Accident Description

Date of Injury*	Time of Injury	Description of Accident*

Cause of Injury	Part of Body*	Job Title*	Date Disability Began*	Date of Death

Name of Witnesses
1.   2.

Accident Reported To*

Accident on Employer's Premises
☐ Yes   ☐ No

Loss Location*

Address   City   State   Postal Code

Date Employer Notified*

Safety Equipment Provided
☐ Yes   ☐ No

Safety Equipment Used
☐ Yes   ☐ No

Injured Employee 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 Employee, Beneficiary or Guardian _____ **Date** _____

Medical

Attending Physician and/or Hospital

Physician: Hospital:

Medical Provider Address

Address   City   State   Postal Code

Medical Provider Phone Number

Type of Medical Treatment Received*
☐ No Treatment   ☐ Treatment Will Be Sought   ☐ Emergency Room/Hospital   ☐ Treatment On-Site by Employer or Medical Staff   ☐ Clinic/Urgent Care

Employer

Employer Name*	Doing Business As*	Federal Employer Identification Number (Tax ID)

Mailing Address*

Address   City   State   Postal Code

Phone Number*

Location of Operation, If Different From Mailing Address

Do you have any reason to question this accident?* If yes, we will contact you for more information. ☐ Yes ☐ No	Prepared By*	Official Title*	Phone Number*	Date

Policy Number*	Contact Person*	Contact Person's Phone Number*	Contact Person's Email

Payroll classification code under which you report employee's wages

Authorized Employer's Signature   **Date**

* Indicates required field

Montana
State Fund