OSHA Log Case #	**First Report** of Injury or Occupational Disease Montana Department of Labor and Industry PO Box 8011, Helena, MT 59604-8011	Adjuster Date Stamp
		Report #:_____

*Required Fields

Worker

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

Mailing Address*	City*	State*	Postal Code*

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

Wages

Date Hired*	Gross earnings for <u>four</u> pay periods preceding the injury

Date/Amount   /   Date/Amount   /   Date/Amount   /   Date/Amount   /

Employment Status ☐ Full-Time ☐ Part-Time ☐ Piece Worker ☐ Seasonal ☐ Volunteer ☐ Other	Number of Days worked per week	Wage	Wage Period ☐ Hour ☐ Week ☐ Month ☐ Day ☐ Bi-Weekly

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

Worked next scheduled shift* ☐ Yes ☐ No	Off work more than 4 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

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 ☐ 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/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 I.D)

Mailing Address	City	State	Postal Code	Phone Number

Location of operation, if different from mailing address	Nature of Business SIC/NAICS Code	Self-Insured ☐ Yes ☐ No

Employer is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	Injured worker is a ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ A member of the employer's (sole proprietor) 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 Name	Claim Administrator Address	Claim Administrator FEIN

Insurer Name	Insurer FEIN

Policy Number	Policy Effective Date	Policy Expiration Date

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