

First Report

Fax: 406-495-5020
Voice: 800-332-6102
Dept Code: (if applicable)

Claims Examiner Date Stamp

OSHA LOG CASE #

Worker

Last Name		First Name		M.I.	Date of Birth		Social Security Number - -	
Home address				City		State	Postal Code -	
Phone Number () -	Education <input type="checkbox"/> Less Than High School <input type="checkbox"/> GED or High School Diploma <input type="checkbox"/> Beyond High School		Gender <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Not Married <input type="checkbox"/> Unknown		Number of Dependents	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.		1	Date / Amount /	2	Date / Amount /	3	Date / Amount /	4	Date / Amount /
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer			Number of days worked per week:		Wage: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Other: <input type="checkbox"/> Day <input type="checkbox"/> BI-weekly <input type="checkbox"/> Year					
In addition to gross earnings cited above worker received: <input type="checkbox"/> Board & Room <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> Other:					Estimated value if any:			Is sick leave available? Used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
Worked next scheduled shift <input type="checkbox"/> Yes <input type="checkbox"/> No		Off work more than 4 work days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		Date Last Worked	Date of Return to work	Full wages paid for date of Injury? <input type="checkbox"/> yes <input type="checkbox"/> No		Salary continued? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Accident Description

Description of Accident (continue on separate sheet if necessary)

Cause of Injury		Part of Body	Nature of Injury	Date and Time of Injury /	
Date disability began:	Date of Death:	Occupation:		Names of witnesses: 1) 2)	
Accident on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accident address or location: City: State: Postal code: -				
Date employer notified:	Accident reported to:			Safety equipment provided? <input type="checkbox"/> Yes <input type="checkbox"/> No	Safety equipment used? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> No treatment <input type="checkbox"/> Emergency room <input type="checkbox"/> Treatment on-site by employer or medical Staff <input type="checkbox"/> Clinic/Dr. Office <input type="checkbox"/> Hospital					

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 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 subject to civil and criminal penalties.

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company		Injured worker is a <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company			A member of the employer's (sole proprietor or) family living in the employer's household.		
Do you have any reason to question this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain fully. Use separate sheet if you need additional space.					Was worker injured while in your employ? <input type="checkbox"/> yes <input type="checkbox"/> no		
Insurance Agent's Name		Insurance Agency		Agent's Telephone Number () -			
Prepared by:		Official title:			Date:		
Payroll Classification Code under which you report employee's wages:		Authorized Employer's Signature: _____			Date: _____		

Insurer Only

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) <input type="checkbox"/>	
Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:	
Insurer's Name:	Third Party Administrator's FEIN:		
Policy Number:	Policy Effective Date:	Policy Expiration Date:	