First Report of Injury and Occupational Disease

PLEASE ANSWER ALL QUESTIONS. AN INCOMPLETE FIRST REPORT WILL DELAY PROCESSING OF YOUR CLAIM.

Worker

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER

JOB TITLE	DEPARTMENT	WORK LOCATION (IE: MAIN HALL, RM 201)	WORK PHONE NUMBER

EMPLOYMENT STATUS	NUMBER DAYS WORKED PER WEEK	DATE HIRED	
☐ FULL TIME ☐ PART TIME ☐ SEASONAL ☐ VOLUNTEER			WORKED NEXT SCHEDULED SHIFT? ☐ YES ☐ NO EXPECT TO BE OFF WORK MORE THAN 4 DAYS? ☐ YES ☐ NO ☐ NOT SURE

DATE LAST WORKED	DATE OF RETURN TO WORK	EDUCATION	GENDER	MARITAL STATUS	NUMBER OF DEPENDANTS
		☐ LESS THAN HIGH SCHOOL ☐ GED OR DIPLOMA ☐ BEYOND HIGH SCHOOL	☐ MALE ☐ FEMALE	☐ MARRIED ☐ SEPARATED ☐ NOT ☐ UNKNOWN	

GROSS WAGE RATE PER	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY	DATE/AMOUNT	DATE/AMOUNT	DATE/AMOUNT	DATE/AMOUNT
		/	/	/	/

IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED: ESTIMATED VALUE IF ANY

☐ BOARD & ROOM ☐ OVERTIME ☐ BONUS ☐ COMMISSIONS ☐ OTHER:

Accident Description

DESCRIPTION OF ACCIDENT

CAUSE OF INJURY	PART OF BODY (IE: LOW BACK, LEFT LEG)	NATURE OF INJURY (IE: STRAIN, SPRAIN, CUT,)	DATE OF INJURY	TIME OF INJURY

DATE SUPERVISOR NOTIFIED	ACCIDENT REPORTED TO	WITNESSES	ACCIDENT ADDRESS OR LOCATION (IE: MAIN HALL RM 201,)

Medical

PHYSICIAN'S NAME	ADDRESS	PHONE NUMBER
HOSPITAL NAME	ADDRESS	PHONE NUMBER

TYPE OF INITIAL MEDICAL TREATMENT RECEIVED:

☐ NO TREATMENT ☐ EMERGENCY ROOM ☐ TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF ☐ CLINIC/DR. OFFICE ☐ HOSPITAL

Supervisor

WAS WORKER INJURED WHILE IN YOUR EMPLOY? ☐ YES ☐ NO	DO YOU HAVE ANY REASON TO QUESTION THIS ACCIDENT? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN FULLY. USE SEPARATE SHEET IF YOU NEED ADDITIONAL SPACE.			
SUPERVISOR'S NAME:	AUTHORIZED SIGNATURE:	SUPERVISOR'S PHONE:	FIRST REPORT PREPARED BY:	DATE:

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 or its agent, rehabilitation records, Social Security records and 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 this 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

DON'T FORGET TO SIGN THIS REPORT!

SEND A SIGNED COPY OF THIS REPORT TO THE PERSONNEL OFFICE & SAVE THE FORM AS A WORD DOCUMENT FILE ON YOUR COMPUTER, THEN ATTACH THE FILE TO AN E-MAIL TO: d_seymour@umwestern.edu
YOU WILL GET AN E-MAIL CONFIRMING RECEIPT.

EMPLOYER: The University of MT-Western 710 S Atlantic, Dillon, MT 59725 (406) 683-7010	**CLAIMS:** INTERMOUNTAIN CLAIMS INC. #140; 100 24th STREET WEST, SUITE 1; BILLINGS MT 59102 406-652-0482 Fax 406-651-0975	
Claim Administrator's Claim Number:	Date Reported to Claim Administrator:	
Campus # 204-Western		