

**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 <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SEASONAL <input type="checkbox"/> VOLUNTEER		NUMBER DAYS WORKED PER WEEK	DATE HIRED	WORKED NEXT SCHEDULED SHIFT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DATE LAST WORKED		DATE OF RETURN TO WORK	EDUCATION <input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> NOT <input type="checkbox"/> UNKNOWN		NUMBER OF DEPENDANTS
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: <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			

**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: <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		

**Supervisor**

WAS WORKER INJURED WHILE IN YOUR EMPLOY? <input type="checkbox"/> YES <input type="checkbox"/> NO	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.			
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: [patricia.lake@umwestern.edu](mailto:patricia.lake@umwestern.edu) YOU WILL GET AN E-MAIL CONFIRMING RECEIPT.**

<b>EMPLOYER:</b> THE UNIVERSITY OF MT-WESTERN 710 S ATLANTIC, DILLON, MT 59725 (406) 683-7010		<b>CLAIMS:</b> 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			