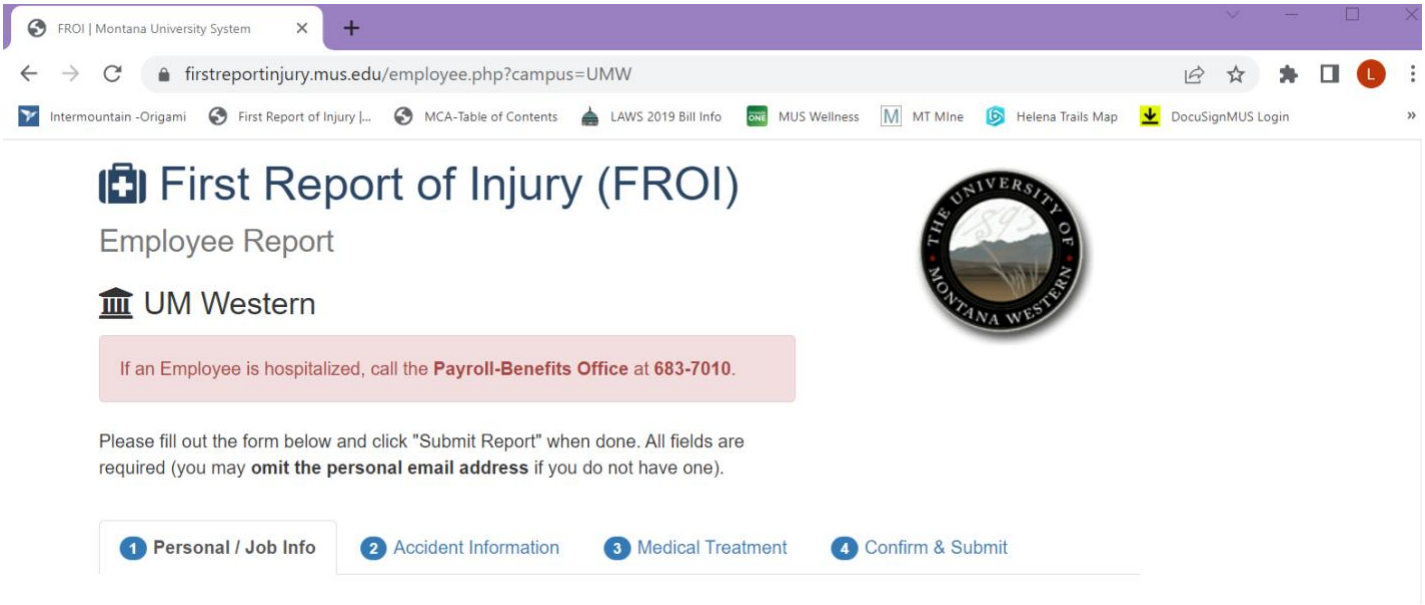

Basic Information

First Name: Bull

Last Name: Dog

Middle Name or Initial: UMW

Date of Birth: Jan 1 2020

Social Security Number (SSN): 123-45-6789

Personal Phone Number: (406) 406-4064 x06

Gender: Male

Address

Address: 1234 Worker Avenue

City: Dillon

State: Montana

Zip: 59725

Position

Job Title
Lead Mascot

Department
Athletics

Work Location
UMW athletics facilities

Work Phone Number
(406) 449-9156

Email
Bigdog@google.com

Report Prepared By
Bull Dog

Employment Status
Full Time

Number of Days Worked (per week)
5

Supervisor

First Name
Canine

Last Name
Mascot

Supervisor's Email
ltietz@montana.edu

Next

Accident Information

Worked Next Scheduled Shift

Yes

Expected to be off work more than 4 days?

Not sure

Date of Injury

09/05/2022

Time of Injury

OD

☑ If condition developed over more than 1 work shift, check box to indicate possible **occupational disease**

Accident Description

Too much enthusiastic tail wagging during home games makes my tail hurt for a few days after after each home football game.

Cause of Injury

repetitive, intense tail wagging

Part of Body

tail

Nature of Injury

overuse or strain

Date Last Worked

09/06/2022

Date Supervisor Notified

09/06/2022

Accident Reported To

Canine Mascot

Witnesses

UMW Cheer squad

Accident Address or Location

Vigilante Field, home team end zone, UMW

Back

Next

Medical Treatment

Type of Medical Treatment

- ○ No treatment at this time
- ○ Plan to seek treatment at...
- ◉ Received treatment at...

Where did you / will you receive treatment?

-- Please Select --

-- Please Select --
Medical Clinic
Emergency Room
Hospital

Back

Next

Medical Treatment

Type of Medical Treatment

- ○ No treatment at this time
- ○ Plan to seek treatment at...
- ◉ Received treatment at...

Where did you / will you receive treatment?

Medical Clinic

Medical Provider

Medical Provider's Name

Bulldog Vet Clinic

Provider's Phone Number

(406) 406-4064 x06

Provider Address

123 Woof Way

City

Dillon

State

Montana

Zip

59601

Employee Report

UM Western

If an Employee is hospitalized, call the **Payroll-Benefits Office** at **683-7010**.

Please fill out the form below and click "Submit Report" when done. All fields are required (you may **omit the personal email address** if you do not have one).

Personal / Job Info | Accident Information | Medical Treatment | 4 **Confirm & Submit**

Confirmation

Please select your method of signature:

- ○ E-signature
- ○ Print, sign and mail

Submit Report

First Report of Injury (FROI)

Employee Report

UM Western

Your report has been successfully submitted to your supervisor.

Your confirmation code is **FROI3785**, please note this code for your records. If you provided an email address, a confirmation has been sent to that email. The FROI has been emailed to your supervisor for input; a confirmation email will be sent to your email (if provided) when the supervisor has completed the supervisor's section of the FROI and submitted it electronically. If you have not already done so, please discuss this incident with your supervisor.

You may print a copy of your completed portion by clicking the **Printable View** button and then printing the form. This printed copy is for your records only and is not for submission. Your supervisor must complete and submit the FROI electronically to finalize the claim filing process.

Printable View

SUPERVISOR, please click the button below to proceed to the SUPERVISOR portion of the claim form.

Supervisor Report

First Report of Injury Supervisor Report

If an Employee is hospitalized, call the **Payroll-Benefits Office** at **683-7010**.

Please fill out the form below and click "Submit Report" when done. All fields are required.

Employee's Injury Information Summary

Employee Name	Bull UMW Dog
Date of Injury	9/5/2022 at 5:00pm
Location of Injury	Vigilante Field, home team end zone, UMW
Accident Description	Too much enthusiastic tail wagging during home games makes my tail hurt for a few days after after each home football game.
Witnesses	UMW Cheer squad
Supervisor Name (as given)	Canine Mascot

For Completion by Supervisor

Basic Information

First Name

Last Name

Phone

Email

Incident Inquiry

Was worker injured while in your employ?

-- Please Make a Selection --

Do you have reason to question this reported incident/injury?

-- Please Make a Selection --

Did you inquire as to the root cause of this incident/injury?

-- Please Make a Selection --

Physical demands of the job

-- Please Make a Selection --

Please indicate the assistance or additional resources required to prevent this from recurring:

Confirmation

Please select your method of signature:

- ○ E-signature
- ○ Print, sign and mail

Submit Report

Please select your method of signature:

- (●) E-signature
- ( ) Print, sign and mail

Electronic Signature

E-signature may *only* be provided by individual making claim (injured employee); *not* by a supervisor or assistant. The print, sign and mail option must be used if employee is unavailable to personally E-sign.

"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the below-named worker. I understand that signing this claim for compensation authorizes the release to the workers' compensation insurer (and its agents) and 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 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."

I, the injured worker or beneficiary, acknowledge that by the dual action of checking the box *and* entering my name as provided below, I am providing my electronic signature.

☐ **I certify as written above**

Enter Full Name

Name of the Injured Employee