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

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 four 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