MONTANA STATEFUND
P.O. Box 4759
Helena, MT 59604-4759

# 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 | Gender | Marital Status | Number of Dependents |
|---|---|---|---|---|
| ( ) - | ☐ Less Than High School<br>☐ GED or High School Diploma<br>☐ Beyond High School | ☐ Male ☐ Unknown<br>☐ Female | ☐ Married ☐ Separated<br>☐ Not Married ☐ Unknown | |

## 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 | Number of days worked per week: | Wage: |
|---|---|---|
| ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer | | ☐ Hour ☐ Week ☐ Month ☐ Other:<br>☐ Day ☐ Bi-weekly ☐ Year |

| In addition to gross earnings cited above worker received: | Estimated value if any: | Is sick leave available? | Used? |
|---|---|---|---|
| ☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other: | | ☐ Yes ☐ No | ☐ Yes ☐ No |

| Worked next scheduled shift | Off work more than 4 work days | Date Last Worked | Date of Return to work | Full wages paid for date of Injury? | Salary continued? |
|---|---|---|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No ☐ Not Sure | | | ☐ yes ☐ No | ☐ Yes ☐ 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? | Accident address or location: City: State: Postal code: - |
|---|---|
| ☐ Yes ☐ No | |

| Date employer notified: | Accident reported to: | Safety equipment provided? | Safety equipment used? |
|---|---|---|---|
| | | ☐ Yes ☐ No | ☐ 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 ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ 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? |
|---|---|---|
| | | ☐ Yes ☐ No |

| Employer is a | Injured worker is a |
|---|---|
| ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company | ☐ Sole Proprietorship ☐ Partnership ☐ A member of the employer's (sole proprietor or) family living in the employer's household. ☐ Corporation ☐ Limited Liability Company |

| Do you have any reason to question this accident? | If yes, please explain fully. Use separate sheet if you need additional space. | Was worker injured while in your employ? |
|---|---|---|
| ☐ Yes ☐ No | | ☐ yes ☐ 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) |
|---|---|---|
| | | |

| 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: |
|---|---|---|
| | | |

# First Report of Injury

## Work-Related Injury & Occupational Disease Reporting

*All DNRC personnel, including EFF's, must fill out a First Report of Injury (FROI) form for every on-the-job injury. This form when submitted protects the employee's right to benefits in the event a seemingly minor injury develops into a more serious condition.*

**Employees** – Notify the supervisor of any on-the-job injury **IMMEDIATELY**

**Supervisors** – Three options for submitting FROI:

1.) Fill out the FROI and fax it to: **(406) 444-1357**, Attn: Paige Tabor **within 24 hours** of the injury. Paige Tabor will check the report to verify completion and forward to Montana State Fund immediately.

2.) Contact **Paige Tabor**, DNRC, Safety Officer **(406) 444-2079** *office*; **(406) 437-2746** *cell;* **(406) 368-2398** *home,* **within 24 hours** of the injury. Inform her of all the details so she may submit the report to Montana State Fund

3.) If you do not have access to a fax machine and cannot reach Paige Tabor to give her the details to file **within 24 hours** of the injury, phone in the report to Montana State Fund directly at **(800) 332-6102, Ext 5337** for Mitzie Saltzman, Team 6.

It is the **supervisor's** responsibility to

- Report the injury to Paige Tabor within 24 hours via fax or phone ***or***
- Submit the report directly to Montana State Fund via phone within 24 hours of the injury ***and*** notify Paige Tabor that a report has been filed *as quickly as possible*.

On fire assignments, the employee's supervisor is his/her immediate supervisor at the incident. If the immediate supervisor is not a DNRC employee, the **injured employee** is then responsible to submit the FROI with the fire supervisor's signature.

Contact the home unit as soon as possible to inform the DNRC supervisor of the injury.

- A hard copy of the FROI may be found in the DNRC Fire & Aviation Management Bureau's 300 Manual or may be obtained from any DNRC area office.
- To print a copy from the MSF website go to: http://www.montanastatefund.com/wps/portal. Go to Reporting an Injury at the bottom left of the screen. Click on First Report of Injury Form. You will not be able to file online. Print the form, fill out, and **fax to Paige Tabor at (406) 444-1357**.

**Helpful Hints:**

- Fill out all sections, except 'Insurer Only' section, as completely and legibly as possible.
- Employee and supervisor should both sign, if available. Supervisor must sign before submitting. Submit this form within 24 hours even if employee is not available to sign, e.g., hospitalized, etc.
- DNRC's federal tax ID # is **81-0302402.**
- Use payroll classification code **9422** for firefighters.
- For 'Employer mailing address,' use the main Helena DNRC address: P.O. Box 201601, Helena, MT 59620-1601. For phone number, use a number where the supervisor can be reached.
- For 'Location of Operation,' use the employee's home unit address.
- Leave the following boxes blank:

  'Employer is a sole proprietorship, partnership, corporation, limited liability company.'
  'Injured worker is a sole proprietorship, partnership, corporation, limited liability company.'
  'Insurance Agent's name'
  'Insurance Agency'
  'Agent's Telephone Number'