

# City of Helena First Report

of Injury or Occupational Disease  
Return to City of Helena Human Resource Office

## Worker

LAST NAME		FIRST NAME		M.I.	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
MAILING ADDRESS					CITY	STATE	POSTAL CODE
PHONE NUMBER	EDUCATION <input type="checkbox"/> LESS THAN HIGH SCHOOL <input type="checkbox"/> GED OR HIGH SCHOOL DIPLOMA <input type="checkbox"/> BEYOND HIGH SCHOOL	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED, DIVORCED, SINGLE, UNMARRIED <input type="checkbox"/> UNKNOWN			NUMBER OF DEPENDANTS	

## Wages

DATE HIRED	GROSS EARNINGS FOR FOUR PAY PERIODS PRECEDING THE INJURY DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT /					
EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> SEASONAL <input type="checkbox"/> PIECE WORKER <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> OTHER		NUMBER OF DAYS WORKED PER WEEK	WAGE	WAGE PERIOD <input type="checkbox"/> HOUR <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> BI-WEEKLY		
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVED <input type="checkbox"/> ROOM & BOARD <input type="checkbox"/> OVERTIME <input type="checkbox"/> BONUS <input type="checkbox"/> COMMISSIONS <input type="checkbox"/> OTHER				ESTIMATED VALUE IF ANY		TIME EMPLOYEE BEGAN WORK
WORKED NEXT SCHEDULED SHIFT <input type="checkbox"/> YES <input type="checkbox"/> NO	OFF WORK MORE THAN 4 WORK DAYS <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE	DATE LAST WORKED	DATE OF RETURN TO WORK	FULL WAGES PAID FOR DATE OF INJURY <input type="checkbox"/> YES <input type="checkbox"/> NO	SALARY CONTINUED <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	ACCIDENT ADDRESS OR LOCATION CITY STATE POSTAL CODE						
DATE EMPLOYER NOTIFIED	ACCIDENT REPORTED TO			SAFETY EQUIPMENT PROVIDED <input type="checkbox"/> YES <input type="checkbox"/> NO	SAFETY EQUIPMENT USED <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> NO TREATMENT <input type="checkbox"/> EMERGENCY ROOM/URGENT CARE <input type="checkbox"/> TREATMENT ON-SITE BY EMPLOYER OR MEDICAL STAFF <input type="checkbox"/> CLINIC/DR. OFFICE <input type="checkbox"/> 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/Supervisor

EMPLOYER NAME CITY OF HELENA	DOING BUSINESS AS N/A	FEDERAL EMPLOYER IDENTIFICATION NUMBER (TAX ID) 81-6001276			
MAILING ADDRESS 316 NORTH PARK AVENUE	CITY HELENA	STATE MT	POSTAL CODE 59623	PHONE NUMBER 406-447-8333	
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS			NATURE OF BUSINESS NAICS CODE 92	SELF-INSURED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
EMPLOYER IS A <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> LIMITED LIABILITY COMPANY		INJURED WORKER IS A <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION <input type="checkbox"/> LIMITED LIABILITY COMPANY <input type="checkbox"/> A MEMBER OF THE EMPLOYER'S (SOLE PROPRIETOR OR PARTNER) FAMILY LIVING IN THE EMPLOYER'S HOUSEHOLD			
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? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> (ATTACH EXTRA SHEETS IF BOX AT RIGHT IS CHECKED)		
CLAIM ADMINISTRATOR'S NAME	CLAIM ADMINISTRATOR ADDRESS PO BOX 6669, HELENA, MT 59604-6669		CLAIM ADMINISTRATOR FEIN	
INSURER NAME MONTANA MUNICIPAL INTERLOCAL AUTHORITY (MMIA)			INSURER FEIN	
POLICY NUMBER PLAN 1 - SELF INSURED	POLICY EFFECTIVE DATE 12/01/2015	POLICY EXPIRATION DATE 11/30/2016		

# First Report of Injury or Occupational Disease Instructions

Workers' compensation insurance is a state-required insurance, which provides medical benefits, wage compensation and rehabilitation to workers injured on the job. Severe penalties can be assessed against an uninsured employer. Neither general liability nor health and accident insurance policies are substitutes for workers' compensation insurance.

The worker and employer may complete this form together or they may each submit a separate form.

## Injured Worker's Instructions

Workers have two reporting requirements: 1) Notify your employer of an on-the-job injury within 30 days of its occurrence and 2) Complete this form as a claim for compensation. The form must be signed and submitted to the employer's insurer within 12 months of the accident. The form must be submitted for all injuries in order to protect your right to benefits in the event a seemingly minor injury develops into a more serious condition.

**Complete a Report of the Injury.** Be thorough in completing all areas except the gray shaded areas. It is important to you that we have complete information. You must provide your Social Security Number (SSN). This is a mandatory requirement that is permitted under Section 7(a) the Privacy Act of 1974 because the Montana Department of Labor and Industry's forms, prescribed by department rules in existence prior to January 1, 1975, have required disclosure of the SSN. The SSN is used as a key identifier of the claimant, and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by the SSN. Use extra sheets of paper if needed. Type or print with a ballpoint pen.

**To ensure that workers' compensation systems will not be disrupted,** the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, 42 USC 1301, et. seq., **permits the disclosure of protected health care information pursuant to the provisions of state laws regarding workers' compensation.** 45 CFR 164.512(l) states:

*"Standard: Disclosures for workers' compensation: A covered entity may disclose protected health information as **Authorized by and to the extent necessary to comply with laws relating to workers' compensation** or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault."*

## Employer's Instructions

Montana law requires employers to complete this form within six days after notice of every on-the-job accident, injury and/or occupational disease (OD) by a worker. Ensure all areas are completed except the gray shaded areas, which your insurer will complete. **It is important that we have complete information.**

Type or print with a ballpoint pen. If you are completing with WORD software, you may tab through the fields. If the injured worker is available to do so, they may file a claim for workers' compensation by completing and signing their portions of this form. You may then complete the employer section.

Send the original immediately to your Human Resources for processing. **SEND THIS FORM WITHIN THE 6-DAY LIMIT EVEN IF THE WORKER IS NOT AVAILABLE TO SIGN.** This form must be submitted even if the employer questions whether or not the reported injury and/or OD are job-related. Additional sheets of paper may be attached, if needed to fully explain all conditions concerning the injury and/or OD.

The United States Department of Labor, OSHA, requires employers to maintain a record of occupational injuries in the employer's office. These forms are kept in the City of Helena's Human Resource office.

## Further Information

City of Helena Human Resources  
Attention: HR/Benefits Specialist  
316 N. Park Avenue  
Helena MT 59623  
Phone: (406) 447-8333  
Fax: (406) 457-8589