

ERD – 991 (Rev. 05/2016 DE)

OSHA Log Case #

First Report
Fax: 406-495-5020. Voice: 800 332-6102
PO Box 4759 Helena, MT 59604-4759

Worker

Adjuster Date Stamp

LAST NAME				F	FIRST NAME				M.I. DATE OF BIRTH			H SOCIAI			SECURITY NUMBER			
MAILING ADDRESS									Crty			S	STATE	ATE POSTAL CODI				
PHONE NUMBER EDUCATION LESS THAN HIGH SCHOOL DII GED OR HIGH SCHOOL DII BEYOND HIGH SCHOOL					LOMA MALE FEMALE UNKNOWN				MARITAL STATUS MARRIED SEPARATED WIDOWED, DIVORCED, SINGLE, UNMARRIED UNKNOWN						Num	BER C	OF DEPENDENTS	
DATE HIRED	GROSS EARNII	NGS FO	R FOUR PAY PERIOI	OS PRECEI	OING THE INJ		Wag	es										
DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT / DATE/AMOUNT / EMPLOYMENT STATUS Number of days worked per week Wage Wage Period																		
FULL TIME VOLUNTEER	PART TIME	ORKER	t				☐ Hour ☐ V			WEEK	MONTH DAY BI-WEEKLY							
IN ADDITION TO GROSS EARNINGS CITED ABOVE WORKER RECEIVE ROOM & BOARD OVERTIME BONUS COMM					SSIONS OTHER				VALUE IF ANY			TIME	TIME EMPLOYEE BEGAN WORK					
I — I — I — I				THAN 4 WORK DAYS NO NOT SURE DATE LAST WORKED				DATE OF RETURN TO WORK			Γ	FULL WAGI DATE OF IN YES						
	Accident Description OB TITLE DESCRIPTION OF ACCIDENT																	
JOB TITLE	DESCRIPTION	N OF A	CCIDENT															
CAUSE OF INJURY			CAUSE CODE	Body	PART PART			E NATURE OF INJURY		NATURE CODE		Е	DATE OF INJURY		Time of Injury			
DATE DISABILITY BEGAN		=	DATE OF DEATH			<u>-</u>	NA 1)	MES OF	OF WITNESSES 2)				•	3)				
ACCIDENT ON EMPLOYER'S PREMISES ACCIDENT ADDRESS OR LOCATION YES NO CITY STATE POSTAL CODE																		
DATE EMPLOYER NOTIFIED ACCIDENT RE				ORTED T					SA			AFETY EQUIPMENT PROVIDED SAFETY EQUIPMENT USED						
Medical													□ No					
ATTENDING PHYSICIAN'S NAME			Address						OSTAL CODE			PHONE NUMBER						
HOSPITAL NAME		Add	DRESS		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																		
						Si	igna	ture										
"This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease, or death of the above named worker. <u>I understand</u> 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. <u>I also understand</u> that if I obtain or exert unauthorized control over workers' compensation benefits to which I am not entitled, I may be prosecuted for theft." Date																		
Signature of injured worker of beneficiary Employer																		
EMPLOYER NAME				Doin	NG BUSINESS AS							FEDERAL EMPLOYER I			IDENTIFICATION NUMBER (TAX ID)			
MAILING ADDRESS			CITY		STATE			POSTAL CODE			Phon			ONE NUMBER				
LOCATION OF OPERATION, IF DIFFERENT FROM MAILING ADDRESS									IATURE OF BUSINESS IAICS CODE				SELF-INSURED? YES NO					
EMPLOYER IS A SOLE PROPRIETORSHIP PARTNERSHIP INJURED WORKER IS A SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION LIMITED LIABILITY COMPANY 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					YES NO 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																		
AUTHORIZED EMPLOYERS SIGNATURE DATE DATE																		
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)													NS 🗌					
CLAIM ADMINISTRATO	OR'S NAME				CLAIM ADM	INISTRATOR A	Address	S	(TITING)	LATINI SHEE	10 H DC	ATT KIGT	.1 15 (DMINISTRA	TOR .	FEIN	
INSURER NAME									Insurer FEIN									
Dorrow Nivo et =-		POLICY EFFECTIVE DATE POLICY EXPIRATION DATE																
POLICY NUMBER									Po	OLICY EFFECT	TIVE DA	TE		POLICY	EXPIRATIO	N D	(TE	