FIRST REPORT of Injury or Occupational Disease

Montana Schools Group
WCRRP
Workers' Compensation Risk Retention Program

Send Completed form to:
MTSBA Insurance Services
PO Box 7029
Helena, MT 59604

Toll Free: 1-877-667-7392
Fax: 406-457-4505

Worker

Last Name	First Name	M.I.	Date of Birth (m/d/yyyy)	Social Security Number

Home Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependants
	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Single ☐ Unknown	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury	Date/Amount /	Date/Amount /	Date/Amount /	Date/Amount /

Employment Status	Number of days worked per week:	Wage:	
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer			☐ Hour ☐ Week ☐ month ☐ Other: ☐ Day ☐ Bi-weekly ☐ year

In addition to Gross Earnings cited above worker received: ☐ Overtime ☐ Bonus ☐ Other	Estimated Value:	Hours worked per day:

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

Occupation of injured worker	Injured assigned to:	School site/Building where inj. emp. works	Payroll classifcation code:
	☐ Elementary ☐ Middle ☐ High school ☐ Amin.		☐ 8868 ☐ 9101

Accident Description

Description of Accident:

Cause of Injury	Cause Code	Part of Body	Part Code	Nature of Injury	Nature Code	Date and Time of Injury /

Date Disability Began:	Date of Death:	Names of witnesses:	1)	2)	3)

Accident on employer's premises?	Accident address or location if off premises: Address:	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:	City	State/Zip	Phone Number:

Hospital Name:	Address:	City	State/Zip	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, occupation 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 fined and/or imprisoned.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name:	Doing Business As:	Federal Employer Identification Number (Tax I.D.)
Laurel Public Schools	Laurel Public Schools	81-6001091

Mailing Address:	City:	State:	Postal Code:	Phone Number:
410 Colorado Avenue	Laurel	MT	59044	(406) 628-3353

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
Same	School District	☐ Yes ☐ No

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:	Date:

Authorized Employer's Signature:	Title:	Date:
	HR	

Insurer

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)

Claim Administrator's Name:	Claim Administrator's Address:	FEIN:
MTSBA INSURANCE SERVICES	PO Box 7029, Helena, MT 59604	81-0460841

Insurance Company Name:	Policy Number:	Policy Effective Date:	Policy Expiration Date:
Montana Schools Group Insurance Authority/ WCRRP			

LAUREL PUBLIC SCHOOLS
ACCIDENT INVESTIGATION REPORT

Employee Name_____ Age____ Occupation_____ School_____

Length of Employment with District_____ In This Position_____

Date of Injury_____ Time_____ ◯AM or ◯PM

Location of Accident_____

Accident Reported To_____ Date Reported_____

Describe the accident. Include the machine, object or substance involved and explain exactly what you, the injured worker, were doing: (Please use other side if more room is needed.)

Were there any witnesses? ◯YES or ◯NO

Name of Witness(es)_____

Witness statement(s): (Please use other side if more room is needed)

If pain gradually occurred, how does the employee relate this problem to work?

What part(s) of the body were injured? (Be specific: i.e. left knee, etc.)

Did employee return to work during next scheduled shift? ◯YES ◯NO

If yes, date you returned to work_____ If no, last day worked (date)_____

Has the worker sought medical treatment? ◯YES or ◯NO

If you answered yes above, please complete the following:

If yes, what date:_____ Attending physician's name_____

Address_____ Phone #_____

_____ _____

Employee Signature & Date Supervisor Signature & Date