First Report
of Injury or Occupational Disease

Adjuster Date Stamp

MACo Claims Department
PO Box 7059, Helena, MT 59604-7059
(406) 442-1178 / (888) 442-8552
FAX (406) 443-4161

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number

Mailing Address	City	State	Postal Code

Phone Number	Education	Gender	Marital Status	Number of Dependents
	Less than High School	Female	Single, Widowed, Divorced	

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		Per Day

In addition to gross earnings cited above worker received:	Estimated value if any	Time employee began work
☐ Room & Board ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other		

Worked Next Scheduled Shift	Off More Than 4 Work Days	Date Last Worked	Date of Return to Work	Full Wages Paid for DOI	Salary Continued
Unknown	Unknown			Unknown	Unknown

Accident Description

Job Title / Department	Description of Accident
Airport	

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	Accident Address or Location: Address	City	State	Postal Code
Yes				

Date Employer Notified	Accident Reported To	Safety Equipment Provided	Safety Equipment Used
		Yes	Yes

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

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 or its agent or UEF, rehabilitation records, Social Security records and 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 ID)

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

Employer is a	Injured worker is a
Unknown	Unknown

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
No	Yes

Prepared By	Official Title	Phone Number	Date

Payroll Classification Code under which you report Employee's Wages	Authorized Employer's Signature	Date
9420 - All Other		