



OSHA Log Case #

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

Adjuster Date Stamp

Worker

Form section for Worker information including Last Name, First Name, M.I., Date of Birth, Social Security Number, Mailing Address, City, State, Postal Code, Phone Number, Education, Gender, Marital Status, and Number of Dependents.

Wages

Form section for Wages including Date Hired, Gross Earnings for four pay periods preceding the injury, Employment Status, Number of Days Worked per Week, Wage, Wage Period, and other details.

Accident Description

Form section for Accident Description including 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, and other details.

Medical

Form section for Medical information including Attending Physician's Name, Address, State, Postal Code, Phone Number, Hospital Name, Address, State, Postal Code, Phone Number, and Type of Initial Medical Treatment Received.

Signature

Signature section containing a legal disclaimer and a line for the Signature of Injured Worker or Beneficiary and Date.

Employer

Form section for Employer information including Employer Name, Doing Business As, Federal Employer Identification Number (Tax ID), Mailing Address, City, State, Postal Code, Phone Number, Location of Operation, Nature of Business, NAICS Code, Self-Insured?, and other details.

Insurer

Form section for Insurer information including Claim Administrator Claim Number, Date Reported to Claim Administrator, Insurer Name, Insurer FEIN, Policy Number, Policy Effective Date, and Policy Expiration Date.