

Department of Public Health and Human Services
Telephone Reporting Worksheet
1-800-332-6102

Montana Mental Health Nursing Care Center
(406) 538-7451

Workers Compensation Claim #: _____

POLICY INFORMATION:

Policy Number: **03-009526-9** Federal Tax ID: **81-0302402** Team #**5**
Employer's Name (as on policy): **DPHHS/Montana Mental Health Nursing Care Center**
Employer's Address: **800 Casino Creek Drive, Lewistown, MT 59457** Department Code: 0002

Callers Name / *Claim Handlers Name* / *Employee ID Number*

EMPLOYEE'S RESPONSIBILITY TO COMPLETE BELOW

Employee Information:

Name: _____ Soc Sec #: _____
Date: _____ Home Address: _____
Phone Number: _____ Occupation: _____ Male or Female: _____
Date of Birth: _____ Marital Status: _____ # of Dependents: _____
Education: Less than High School _____ GED or High School _____ Beyond High School _____
Employment Status (full or part time) _____ Date of Hire: _____

Accident Information:

Describe how the accident happened and give cause. Explain what the worker was doing when injured. Give full details on all factors which led or contributed to the accident. Use a separate sheet of paper if you need additional space:

Date of Injury: _____ Time of Injury: _____ Nature of injury (cut, sprain, etc.) _____

What specific object caused injury _____ Part of body affected (arm, leg, etc) _____

Witness to accident: 1) _____ 2) _____ 3) _____

Employee Signature

SUPERVISOR'S RESPONSIBILITY TO COMPLETE

Supervisor:

Was accident on Employer's premises: _____ Was employee in your employ at time of accident: _____
Address or location where accident occurred: City: _____ State: _____ Zip: _____

Were you notified of the accident _____ Date: _____ Time: _____ How: _____

Describe the accident as you understand it: _____

Do you have any reason to question this accident: _____

Why: _____

Was safety equipment provided? Yes: ____ No: ____ Was safety equipment used? Yes: ____ No: ____
To the best of your knowledge, identify the cause of this accident such as lack of job training, unsafe conditions,
improper work habits, etc. Please explain: _____

Do you have any corrective action proposal? Please Explain: _____

Time Loss Information:

Last day employee worked: _____ Did employee return to work on next regular shift

Will time loss exceed 6 days _____. If no, how long

(If applicable) Has employee been released by the Physician: _____ When: _____

Supervisor's Signature: _____ Date: _____

Medical Information:

Was a Physician seen? ____ Yes ____ No

Was Work Missed due to accident? ____ Yes ____ No