



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, Employment Status, Number of Days Worked, Wage, Wage Period, and other details.

Accident Description

Form section for Accident Description including Job Title, Description of Accident, Cause of Injury, Date Disability Began, Date of Death, Names of Witnesses, and Safety Equipment provided.

Medical

Form section for Medical information including Attending Physician's Name, Address, State, Postal Code, Phone Number, Hospital Name, 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, 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.