



# City of Kalispell

## EMPLOYEE'S REPORT OF JOB RELATED INJURY / ILLNESS & Workers Compensation Claim Form

Human Resource's Phone: 406-758-7757 Fax: 758-7847

◆ **WORKER INFORMATION**

**PLEASE PRINT CLEARLY!**

Full Name of Employee (First, MI, Last):		Payroll #:	Home Phone:	Work Phone:	Social Security Number:
Mailing Address:				City:	Zip Code:
Sex:	Date of Birth	Marital Status:	Education (Highest Grade Completed):	Number of dependants living at home:	

◆ **EMPLOYMENT INFORMATION**

Years in Current Job:	Normal number days worked / week:	Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Temporary <input type="checkbox"/> Seasonal <input type="checkbox"/> Volunteer
Date of Hire:	Department:	Employees' Supervisor:

◆ **INCIDENT INFORMATION**

Date of Report:	Time of Report:	Occupation at time of injury / illness:	Supervisor taking report:
Date of Incident:	Time of Incident	Specific Location or Address:	
Describe in detail what happened that caused the injury / illness:			
Part(s) of body affected: Example: Back, Wrist, Leg, etc.		Nature of Injury (s): Example: Strain, Sprain, Burn, Pain, Numb, etc.	
Have you previously injured this part of your body before? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, explain when and what happened.			
List name(s) of witnesses:	List employee(s) you were working with.	Was safety equipment issued and used? Yes <input type="checkbox"/> No <input type="checkbox"/>	

◆ **MEDICAL INFORMATION**

Have you or are you planning on seeing a licensed health care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes. Who and when.	
Did you go or are you planning on going to the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes. When and where.	
What type of medical treatment have you received?	
Your last day worked was?	Will you be working your next scheduled shift? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain.

This is a report and claim for workers' compensation benefits due to an on-the-job injury or occupational disease. I understand that signing this report authorizes the release of rehabilitation records, Social Security records, and health care information relevant to this claim to the workers' compensation insurer, the insurer's agents and the City of Kalispell. All information will be strictly confidential pursuant to HIPAA and Public laws.

\_\_\_\_\_  
Employees Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor's Signature

\_\_\_\_\_  
Date

**NOTE: ONCE COMPLETED FORWARD ORIGINAL TO HUMAN RESOURCES IMMEDIATELY!**



# City of Kalispell

## EMPLOYEE'S WORK STATUS REPORT FORM

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**Employees:** This report should be given to your health care provider for them to complete at the time of your visit. Once completed immediately return the form to your supervisor, who will forward to Human Resources.

**Dear Health Care Provider:**

So that we can comply with reporting requirements and determine the employee's work status, please complete the following information and return to us as soon as possible. Do not provide any data concerning the employee's genetic information including information about the employee's family medical history.

**PLEASE PRINT!**

Name of Employee:	Payroll #:	Date employee was treated:
Medical Treatment Provided:		
List any prescriptions given to employee:		
Does the employee have any restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please be specific.		
Duration of restrictions:		
Will there be follow-up? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes. When?		
Comments:		

\_\_\_\_\_  
Health Care Provider Signature

\_\_\_\_\_  
Health Care Provider Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number



## City of Kalispell

201 1<sup>st</sup> Ave East,  
Kalispell, MT 59903

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Fax: 758-7847

### **Workers Compensation – Information for Injured Employee**

1. Injury reports are to be completed and turned into the Human Resources Department immediately! Delays could result in your not being eligible for benefits!
2. Once you have filed your injury report with your Supervisor, they will forward to HR.
3. The Human Resources Department will then formally file the report with our Workers Compensation Adjuster Montana Municipal Insurance Authority (MMIA).
4. You will be contacted by MMIA as to the status of your injury claim.
5. You will also be assigned a “claim number” which should be used anytime you are seeking treatment from a health care provider or to purchase prescriptions.
6. Advise your health care provider or pharmacist that this is a Workers Compensation Claim and the adjuster is MMIA. The bills should be mailed directly to MMIA.
7. Until you receive the claim number you can provide the health care provider or pharmacy your Name, Date of Birth, Social Security Number and Date of Injury.
8. Make sure to keep your supervisor informed of the following:
  - a. Your current health status as a result of the job-related injury or illness.
  - b. If you have any restrictions and the duration of.
  - c. If you are taking medications that may affect your ability to safely perform your job.
  - d. You should always discuss with your health care provider what health effects can occur as a will result from taking prescription medications.
9. Should you have any questions about your workers compensation claim, you can the City of Kalispell Human Resources Department at 758-7757 or MMIA directly at:

Montana Municipal Insurance Authority  
P.O. Box 6669  
Helena, MT 59604-6669  
Phone: 1 - 800 - 635 - 3089.  
Fax: (406) 449 - 7440

