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: ☐ Full Time ☐ Part Time ☐ Temporary ☐ Seasonal ☐ 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? ☐ Yes ☐ 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 ☐ No ☐

♦ MEDICAL INFORMATION

Have you or are you planning on seeing a licensed health care provider? ☐ Yes ☐ No If yes. Who and when.

Did you go or are you planning on going to the hospital? ☐ Yes ☐ 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? ___Yes ___ 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!

Click Here to Submit to HR

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? ☐ Yes ☐ No If yes, please be specific.		
Duration of restrictions:		
Will there be follow-up? ☐ Yes ☐ No If yes. When?		
Comments:		

_____ _____ _____

Health Care Provider Signature | Health Care Provider Printed Name | Date

_____ _____ _____

Address | Phone Number | Fax Number

Click Here to Submit to HR

City of Kalispell
201 1st Ave East,
Kalispell, MT 59903
Human Resource's Phone: 406-758-7757
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 adjustor 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 safety 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

City of Kalispell

Supervisor's Follow-up
Injury/Illness &/or Incident report

Click Here to Submit to HR

Date & Time of Injury/Incident:	Department(s) Involved:	Date reviewed by Supervisor:
Employee(s) Involved:		
Brief description of Incident:		
Supervisor's Comments, Corrective Actions & Signature _____ Signature of Supervisor		
Department Head's Comments & Signature: _____ Signature of Director/Chief		
Additional Comments:		

NOTE: ONCE COMPLETED, FORWARD ORIGINAL TO HUMAN RESOURCES ALONG WITH ANY SUPPORTING DOCUMENTATION