

**DEPARTMENT OF HUMAN RESOURCES**

200 W. Broadway
Missoula, MT 59802

www.missoulacounty.us

PHONE (406) 258 4874

FAX (406) 258 4863

NOTICE TO SUPERVISOR OF INJURY OR EXPOSURE

This document does not serve as a claim for benefits under Workers' Compensation

EMPLOYEE'S INFORMATION: Social Security Number: _____ Date of Birth: _____

Injured Worker's Name: _____ Home Phone: _____

Home Address: _____ City: _____ ST: _____ Zip: _____

Employer/Department/Job Title: _____ Work Phone: _____

Normal Work Schedule: Days per week / Hrs per day / Shift: _____

If injured worker is NOT an employee, what is their relationship to your department, (ex: volunteer, community service worker, etc.) _____

INFORMATION ABOUT ACCIDENT, EXPOSURE OR ONSET OF SYMPTOMS

1. Date of injury or onset of symptoms: _____ Time: _____

2. When did you first think symptoms might be work related? Date: _____ Time: _____

3. Location of accident / incident: _____

4. Witness(es) to incident: _____

5. Nature of injury (e.g., cut, sprain, etc.): _____

6. Part(s) of body injured: _____

7. How did the incident occur? Give full details which led to the injury or illness and any objects or substances involved. If more space is needed, attach a page. _____

8. Was safety equipment provided? ☐No ☐Yes 9. Was safety equipment used? ☐No ☐Yes10. Was work missed: ☐No ☐Yes-Indicate days/hours missed: _____11. Has there been any similar prior injury or illness? ☐No ☐Yes-Explain on separate sheet of paper.12. Was medical treatment other than First Aid received for this injury? ☐No ☐Yes Was it emergent? ☐No ☐Yes13. Are there plans to seek medical treatment for this injury? ☐No ☐Yes **If yes, please call 258-3272 TO OBTAIN****PRIOR AUTHORIZATION FOR NON-EMERGENT MEDICAL TREATMENT OTHERWISE THE COSTS INCURRED MAY BE FORWARDED TO YOU FOR PAYMENT CONSIDERATION**

If you sought **EMERGENT medical treatment** provide name, address, and phone number of provider(s) as well as date(s) of treatment: _____

Employee Signature (*if available) X _____ Date: _____

*****Supervisors, do not delay sending this notice if employee is not available for signature.****SUPERVISOR'S INFORMATION:**

Print Supervisor's name legibly: _____

Do you question information provided in this notice: ☐No ☐Yes- Explain on separate sheet of paper and attach.

Date you were notified of incident: _____ Time: _____

Supervisor's Signature**Date****Phone*********Return completed form to Human Resources*********Incomplete forms will be returned to supervisor**

Date Notice of Injury was: received/ logged in HR _____ Faxed to Risk/Benefits _____ Copy sent to worker _____

Distribution: White and Yellow - Human Resources Pink - Supervisor **Form last updated: 07/01/2021**