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 ☐Yes
10. 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 ☐Yes
13. 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**