Employee from Another Agency – EFF Hire Packet Forms and Policies

******RETURN TO HELENA-PAYROLL******

PLEASE PRINT ALL INFORMATION CLEARLY TO ENSURE PROMPT PAYMENT

EFF Name _____

Location _____ RFD/VFD _____

(Land Office and/or Unit Name) *(if applicable)*

Sent to Payroll By: _____

(Contact Person) *(Date)*

Return this coversheet with documents checked off below.

Required Forms #1-7 (Unless otherwise noted)		
1.		EFF Hiring Packet Checklist
2.		EFF Employment Conditions Acknowledgement
3.		Decedents Warrant
4.		Selective Service
5.		Social Security SSA-1945 (not covered by state)
6.		Incident Behavior
7.		Confirmation of Receipt of DNRC Policies by Emergency Firefighters (EFF's)
Optional - Include only as needed		
8.		Fuel Card Use Form
9.		RMTD Vehicle Use Acknowledgement Form
Reference & Information		
10.		EFF Information Sheet
11.		State Fund 1st Report Instructions
12.		State Payroll Calendar
13.		Travel Voucher Instructions
14.		*Any Additional Documents:*

Home Agency Name: _____

Home Agency Payroll Contact: _____

Employee ID: _____

DNRC Area/Unit Office Personnel Only (57690024)

Activate DNRC e-mail account: Yes___ No___ Approval: _____ _____ _____

Signature Print Name & Position Date

Questions – Please Contact DNRC Payroll at 444-5735 Revised 12/2018

EMERGENCY FIRE FIGHTER EMPLOYMENT CONDITIONS ACKNOWLEDGEMENT

By signing this form, you agree and acknowledge receipt of it, and understand and agree that employment with the Montana Department of Natural Resources and Conservation (DNRC) as an Emergency Fire Fighter (EFF) includes the following conditions:

1. You are being hired by DNRC as an EFF. An EFF is a short-term worker under the Montana Code Annotated, which are laws that apply to DNRC. Although you may fill out forms ahead of time to be ready to work, your date of initial hire as an EFF is the first date that you are dispatched or called into work by the DNRC.

2. As an EFF, you are not hired under a competitive process.

3. Your EFF period of potential employment will terminate eleven months from the date of initial hire.

4. The DNRC has a one-year probationary period for permanent employees. As an EFF, you cannot complete the probationary period to attain status as a permanent DNRC employee. Subsequent employment as an EFF does not count toward the probationary period or longevity (years of service with the State). Each hire as an EFF begins a new period of employment.

5. Subject to emergencies under 76-13-104, MCA, an EFF short-term worker is a person who:
   (a) is hired by DNRC for an hourly wage established by DNRC;
   (b) may not work for DNRC for more than 90 working days from the date of hire in a continuous 11-month period;
   (c) is not eligible for permanent status;
   (d) may not be hired into another position by DNRC without a competitive selection process; and
   (e) is not eligible to earn leave or holiday benefits and is not eligible to earn group health benefits.

6. The term “working day” means a day, of any number of hours (not to exceed 24 hours), on which you are dispatched and assigned by DNRC to report to a worksite. Each working day, no matter its number of hours, counts toward the 90-day total.

7. You will only be asked to work hours on an as-needed basis by the DNRC. Because you will work only on an “as-needed” basis, DNRC does not guarantee that you will work any number of days and, it is possible that you may not be hired to work any days. DNRC retains the discretion to assign as many or as few hours as it chooses based on its business needs, and makes no promise that full-time hours will be available.

8. You will be paid only for the hours you work.

9. Employment as an EFF does not guarantee that you will be hired again, in any capacity or at any time, by DNRC.

10. DNRC may, in its sole discretion, issue you a cell phone and/or a credit card for use as an EFF. Any cell phone or credit card issued to you by DNRC will be used for DNRC work-related purposes. Within five (5) calendar days of the end of your employment, you will return to DNRC any cell phone or credit card issued to you by DNRC.

11. Federal form I-9, Section 1, should be completed, signed and dated by you, the EFF, and turned into the DNRC hiring office with appropriate documentation. Once reviewed and verified by the DNRC representative, Section 2 is completed, signed and dated. You will then be placed in a “Ready Pool” status and you may or may not be mobilized or activated for the fire season. If you are mobilized or activated, then your first day of employment will be entered on the I-9.

Your signature is your acknowledgment that you have read, understand, and agree to the above conditions of employment as an EFF short-term worker.

_____	_____	_____
Employee’s Signature	Print Employee’s Name	Date

LEGAL DESIGNATION OF PERSON AUTHORIZED TO RECEIVE DECEDENT'S WARRANTS

Instructions for Employee

1. Complete the Beneficiary Designation portion of this form. This form must be typed or printed legibly in ink.
2. Provide designee's full legal name (example "Mary Lynn Smith" or "To the Estate of Jane Smith"). The designee name cannot be "Mrs. John E. Smith".
3. No erasures or corrections in the designee's name can be accepted. If an error is made, complete a new form.
4. Inform your HR/payroll personnel when designee's address changes.
5. Sign this form in ink and submit to your agency HR/payroll personnel.
6. Designee may be changed at any time by completing another form and submitting to your agency HR/payroll personnel. You are requested to update your designee every calendar year.

Beneficiary Designation For Decedent's Final Warrants

Pursuant to §2-18-412, MCA, I hereby designate the following person who, notwithstanding any other provision of law, shall be entitled upon my death to receive all state warrants, excluding payment of death benefits and refund of employee retirement contributions, payable to me as a result of my employment with the State of Montana had I survived.

All information is **required**.

Name of Designee _____
First Middle Last

Mailing Address _____
Street or PO Box City State Zip Code

Social Security Number _____ Date of Birth _____

My signature on this document indicates:

1. I understand this is a legally binding document.
2. I hereby revoke any previous designation filed by me.
3. If the above named designee cannot be contacted within sixty days after the date of my death, this designation shall be void and the warrant will be reissued to my estate.
4. This designation will remain in full force and effect until revoked by me in writing.

Employee Name _____ _____
First Middle Last Social Security Number

_____ _____
Employee Signature Date

Instructions to Employer

Review above information for proper completion by employee and reaffirm to employee, this is a **legally binding document**. Place document in employee's file. Have your employees periodically review their designation.

1. Upon death of employee, complete the information below. The Certifying Officer should be the agency head or personnel officer. ***Carefully follow the checklist for Deceased Employee available on the MINE website.***
2. Send two copies of this form to the SHRD Human Resources Information Services Bureau and retain original in employee's file.
3. If death occurs after the warrant has been issued but before it has been negotiated, recover the warrant (if possible) and submit to the SHRD Human Resources Information Services Bureau.

_____ _____ _____
Date of Death Certifying Officer Signature Date

FOR USE BY DEPARTMENT OF ADMINISTRATION - WARRANT WRITING

Agency Contact _____ Agency Phone # _____

Employee Name _____ Beneficiary Name _____ Vendor # _____

Voucher # _____ Done By _____ Date _____ Approved by _____ Date _____

Replacement # _____ Date _____ Journal # _____ Date _____ Approved By _____ Date _____

Statement of Selective Service Registration Status

If you are a male born on or after January 1, 1960, and are at least 18 years of age, the Montana Compliance with Military Selective Service Act requires that you register with the Selective Service System unless you meet certain exemptions under Selective Service law. If you are required to register, but fail to do so, you are not eligible for employment with the state of Montana

.

Certification of Registration Status

Check one:

[ ] I certify I am registered with the Selective Service System.
[ ] I certify I am exempt from the registration requirements of Selective Service.
[ ] I certify I have not registered with the Selective Service System.
[ ] I certify I have not reached my 18th birthday and understand I am required to register at that time.

Non-registered Men Under Age 26

If you have reached your 18th birthday, are under age 26, and have not registered, you should register promptly. State of Montana agencies are prohibited from hiring you unless you are registered.

Non-registered Men Age 26 or Over

If you were born on January 1, 1960 or later, and were required to register but did not do so, you can no longer register under Selective Service law. State of Montana agencies are prohibited from hiring you unless you can prove that your failure to register was neither knowing nor willful. You may request that an agency make a decision regarding your failure to register. Return this certification statement to the agency along with a written statement that requests a review and explains the reasons for your failure to register. You also should submit other documentation that proves your failure to register was neither knowing nor willful.

False Statement Notification

A false statement may be grounds for not hiring you, or for dismissing you if you have already begun work. Also, you may be punished by fine or imprisonment.

_____ _____

Legal signature of individual Date signed

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ Employee ID # _____
Employer Name Department of Natural Resources & Conservation Employer ID # 81-0302402

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision
Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500-$400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information
Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778 or contact your local Social Security office.

Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website: www.socialsecurity.gov/online/ssa-1945.pdf.
Paper copies can be requested by email at: ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Form **SSA-1945** (01-2013)
Destroy Prior Edition

Incident Behavior

Common Responsibilities
Volunteers and Single Resource Casual Hires

Inappropriate Behavior:

It is extremely important that inappropriate behavior be recognized and dealt with promptly. Inappropriate behavior is all forms of harassment including sexual and racial harassment. **Harassment in any form will not be tolerated.** When you observe or hear of inappropriate behavior you should:

- Inform and educate subordinates of their rights and responsibilities.
    - Tell the harasser to stop the offensive conduct.
- Provide support to the victim.
- Report the incident to your supervisor and the individuals' supervisor, if the behavior continues. Disciplinary action may be necessary.
- Develop appropriate corrective measures.
- Document inappropriate behavior and report it to the appropriate incident manager or agency official.
- While working in and around private property, recognize and respect all private property.

Drugs and Alcohol:

- Non-prescription unlawful drugs and alcohol are not permitted at the incident.
- Use of medical marijuana on incidents is prohibited.
- Possession or use of these substances will result in disciplinary action.
- During off-incident rest periods, personnel are responsible for proper conduct and maintenance of fitness for duty. Drug or alcohol abuse resulting in unfitness for duty will result in disciplinary action.
- Be a positive role model. Do not be involved with drug or alcohol abuse.
- Report any observed drug or alcohol abuse to your supervisor.

I have read and I understand the above described incident behavior responsibilities:

Signature _____ Date _____

Confirmation of Receipt of DNRC Policies by Emergency Firefighters (EFF's)

By signing below, I agree that as a condition of employment with the State of Montana, Department of Natural Resources and Conservation (DNRC), I will comply with the following listed DNRC policies:

Initials	Required Policies	Number	Date
	Drug Free Workplace Policy	P-DNRC-HR-022	06/25/02
	Model Rules of Conduct Policy	P-DNRC-HR-041	11/18/07
	Public Information Policy	P-DNRC-OP-004	09/10/12
	Sexual Harassment Policy	P-DNRC-HR-004	09/05/95
	Substance Abuse/Use Policy	P-DNRC-HR-010	11/21/95
	State Vehicle Use Policy (RMTD-ARM)	P-DNRC-HR-037	03/06/13
Optional Policies – Include only as Needed			
	Drug & Alcohol Testing (required for Empl w/CDL)	P-DNRC-HR-006	10/03/95
	Drug & Alcohol Testing Addendum (required for Empl w/CDL)	P-DNRC-HR-006A	11/01/96
	State Fuel Card Policy		01/22/18
	State Employee Travel Policy		11/13/18

I acknowledge that the policies have been made available to me, and declare that, prior to signing this form; I have read and do understand these policies.

_____ _____

Print Name Date

STATE OF MONTANA
FUEL CARD USE EMPLOYEE AGREEMENT

1. I have read, understand, and will comply with the Fuel Card Policy.
2. I understand I am required to use ethanol-blended gasoline when the manufacturer allows and I am prohibited from using premium grade fuel unless required by the vehicle operations manual.
3. I agree to use the card for all fuel purchases unless obtained from a state-owned bulk site with a manual transaction process.
4. I will immediately notify the authorizing official if a card is lost or stolen or if my PIN is compromised.
5. I understand that I am required to comply with internal control procedures.
6. I agree not to share my Personal Identification Number (PIN) with any other person.
7. I understand I can only use the card for fuel and authorized vehicle maintenance purchases for state-owned vehicles.
8. If I misuse the card for personal purchases, I authorize the State to deduct from my salary or from other monies owed me, an amount equal to the total of the personal purchases. I also agree to allow the State to collect any amounts owed by me even if the State no longer employs me.
9. I understand improper use of this card may result in disciplinary actions, including termination of employment and criminal action.
10. I understand the State may terminate my card use privileges at any time for any reason.

Employee Signature	Authorizing Official's Signature
Employee Printed Name	Authorizing Official Printed Name
Date	Date

DEPARTMENT OF ADMINISTRATION
RMTD VEHICLE USE POLICY
ACKNOWLEDGEMENT FORM

I, _____ am currently employed by _____
understand and agree that my use of the any and all vehicles owned, rented and/or leased by the State, my Department, my Division
or my work unit shall be exclusively related to doing the business of the State of Montana.

I also understand that I am not to use such vehicles for any other reason whatsoever (human life threatening medical emergency excepted).

I agree to operate such vehicles in a safe, prudent, and lawful manner at all times and to comply with the state's motor vehicle laws and policies.

I will wear seat belts at all times and assure that all vehicle occupants do the same when the vehicle is in motion. I will not permit any other person to operate the vehicle, unless such use is made part of this agreement. I will not permit unauthorized passengers to ride in the vehicle without the prior written approval of the Risk Management and Tort Defense Division. I will not carry or consume alcoholic
beverages in a state vehicle or drive a state vehicle out of the State of Montana without prior approval of a state agency.

I truthfully state that I have a valid, non-conditional driver's license and that my license is not currently under suspension. I do truthfully state that I have been convicted in the past 36 months of the following motor vehicle violations (please list):

Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____
Type of Conviction_____ Date:_____

NOTE: If you have listed one or more moving violation convictions during the past 36 months, you must attach your explanation for each conviction or provide a copy of your driver's record along with this signed form.

I understand that, in accordance with the state vehicle use rule ARM 2.6.201 through ARM 2.6.214, if my total conviction points for convictions after 10/12/01 exceed 5 points for a single infraction or an accumulation of 12 points within the past 36 months, I will the report the infraction to supervisor. If my conviction points exceed 15, I understand that I may not be allowed to operate a state vehicle.

I understand that any material false statement or use of the vehicle not permitted by this agreement will require me to assume the full legal and financial consequences of my actions. **Important Notice to Driver: Do not sign below unless you have read and understood this document.**

_____ _____
Driver Signature **Date**

Note: Each state employee must read and understand the provisions of the State Vehicle Use Rule (ARM 2.6.201 through ARM 2.6.214). Supervisors must obtain written documentation of the same by having each employee sign a vehicle use agreement at new employee orientation and periodically thereafter. A copy of the signed agreement must be kept in each employee's personnel file. A sample vehicle use agreement is hereby provided. Agencies may develop their own forms or processes. Please contact the Risk Management & Tort Defense Division with additional questions.

Montana DNRC Emergency Firefighter (EFF) Information Sheet

HIRING

The state of Montana DNRC hires casuals, or temporary employees, as state EFF's. They are not federal AD's. All hiring paperwork is normally completed and submitted to DNRC payroll in Helena prior to an incident. While EFFs are considered Short Term Workers, they are not held to the 90-working day threshold.

- Workers Compensation Insurance: EFF's are covered under MT Workers Compensation Insurance (MT State Fund: 1-800-332-6102, team 6). See *First Report of Injury* and reporting instructions.
- Taxes & Benefits: State and federal taxes are deducted from EFF gross earnings and state unemployment insurance is paid by the state. (Social Security taxes are not deducted from EFF earnings). EFF's are not entitled to sick or annual leave and are not required to participate in the state retirement plan unless already enrolled or work more than 960 hours per year.
- Entitlements: If incident commissary is available, EFF's are granted commissary privileges on a cash only basis. EFF's earn overtime on greater than 8 hours in a day and greater than 40 hours in a week. Though time is kept on the OF-288, overtime does not need to be computed on an incident; it will be figured when EFF time reports are processed by DNRC Payroll. EFF's are not entitled to hazard pay, unless specially trained and working on OU3 asbestos area, or any other pay differentials. State employees including EFF's are entitled to one compensated R&R day upon return home from a 14-day assignment; if the IC feels this is warranted, it can be provided by the incident prior to Demob.
- Pay Rates: EFF pay rates are determined by the nature of the work assigned. See the NRCG supplement to Chapter 10 of the SIIBM at the following website for Montana EFF pay rates. See NRCG supplement to Chapter 50 for additional EFF info. http://www.fs.fed.us/r1/fire/nrcg/Committees/business_committee.htm

TRAVEL

When in travel status, occasionally meals or lodging expenses must be paid out of pocket. Reimbursement for such expenses will be in accordance with State of Montana travel policies and state per diem rates. Montana travel and per diem meal rates (in state or out of state, as applicable) always apply, regardless of host agency or location of incident. Lodging reimbursement rates are generally at the current federal lodging rate. Lodging receipts must be submitted; reimbursement is at actual cost. Requests for reimbursement of travel expenses must be documented on DNRC a Travel Expense Voucher, submitted to the home unit. Montana travel and per diem policies and forms can be found at the following website: http://dnrc.mt.gov/forestry/fire/business/forms.asp. Higher meal rates may be available in-state for suppression personnel, please contact your hiring office for more information and Chapter 310 of the DNRC Fire Business (300) Manual.

MT Per Diem meal rates (flat rates, receipts not required):

In state:	Breakfast	$5.00	Out of state:	Breakfast	$13.00
	Lunch	$6.00		Lunch:	$14.00
	Dinner	$12.00		Dinner:	$23.00
		$23.00 per day			$50.00 per day

VEHICLE USE

The dispatch office should arrange for travel to and from the incident. Prior authorization is required for use of a personal vehicle. The State of Montana Personal Vehicle Use Authorization Form must be completed and approved by an authorized agency official. If approved to use a personal vehicle, the EFF will be reimbursed for mileage at state rates. This request for reimbursement should be documented on a Travel Expense Voucher. If the vehicle is specifically ordered on a Resource Order for use on the incident, it should be signed up on an EERA at the home unit and paid at a daily and/or mileage rate, as applicable.

PAYMENT DOCUMENTS

ALL PAYMENTS FOR EFF'S AND/OR LOCAL GOVERNMENT FORCES ARE PROCESSED THROUGH THE HOME UNIT (DNRC HIRING OFFICE). The crew representative (or individual) must bring the original payment documents back to the home unit for processing. MT DNRC is the only payment agency for EFF's and local government equipment from Montana.

HOME UNIT CONTACT INFORMATION (hiring Land Office or Unit Office)

Address: _____ Phone: _____

_____ Contacts: _____

_____ _____

DNRC hiring official: Attach blank First Report of Injury and reporting instructions to this form; give to each EFF at time of hire.
EFF: Carry this form and a copy with you on incident assignments. Present copy to Finance Section.

Rev. 2/2019

MONTANA STATEFUND
P.O. Box 4759
Helena, MT 59604-4759

First Report

Fax: 406-495-5020
Voice: 800-332-6102
Dept Code: (if applicable)

Claims Examiner Date Stamp

OSHA LOG CASE #

Worker

Last Name	First Name	M.I.	Date of Birth	Social Security Number
				- -

Home address	City	State	Postal Code
			-

Phone Number	Education	Gender	Marital Status	Number of Dependents
( ) -	☐ Less Than High School ☐ GED or High School Diploma ☐ Beyond High School	☐ Male ☐ Unknown ☐ Female	☐ Married ☐ Separated ☐ Not Married ☐ Unknown	

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount /	2 Date / Amount /	3 Date / Amount /	4 Date / Amount /

Employment Status	Number of days worked per week:	Wage:
☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer		☐ Hour ☐ Week ☐ Month ☐ Other: ☐ Day ☐ BI-weekly ☐ Year

In addition to gross earnings cited above worker received:	Estimated value if any:	Is sick leave available?	Used?
☐ Board & Room ☐ Overtime ☐ Bonus ☐ Commissions ☐ Other:		☐ Yes ☐ No	☐ Yes ☐ No

Worked next scheduled shift	Off work more than 4 work days	Date Last Worked	Date of Return to work	Full wages paid for date of Injury?	Salary continued?
☐ Yes ☐ No	☐ Yes ☐ No ☐ Not Sure			☐ yes ☐ No	☐ Yes ☐ No

Accident Description

Description of Accident (continue on separate sheet if necessary)

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury
			/

Date disability began:	Date of Death:	Occupation:	Names of witnesses:
			1) 2)

Accident on employer's premises? ☐ Yes ☐ No	Accident address or location: City: State: Postal code: -

Date employer notified:	Accident reported to:	Safety equipment provided?	Safety equipment used?
		☐ Yes ☐ No	☐ Yes ☐ No

Medical

Attending Physician's Name	Address	State	Postal Code	Phone Number
			-	( ) -

Hospital Name	Address	State	Postal Code	Phone Number
			-	( ) -

Type of initial medical treatment received: ☐ No treatment ☐ Emergency room ☐ Treatment on-site by employer or medical Staff ☐ Clinic/Dr. Office ☐ Hospital

Signature

This is my claim for workers' compensation benefits due to the on-the-job injury, occupational disease or death of the above named worker. **I understand** that signing this claim for compensation authorizes the release of rehabilitation records, Social Security records and health care information (medical records) relevant to this claim to the workers' compensation insurer and the insurer's agents. **I also understand** that if I obtain or exert unauthorized control over workers' compensation benefits, I may be subject to civil and criminal penalties.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)

Mailing Address	City	State	Postal Code	Phone Number
			-	( ) -

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
		☐ Yes ☐ No

Employer is a	Injured worker is a	
☐Sole Proprietorship ☐ Partnership ☐Corporation ☐ Limited Liability Company	☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company	☐ A member of the employer's (sole proprietor or) family living in the employer's household.

Do you have any reason to question this accident? ☐ Yes ☐ No	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ? ☐ yes ☐ no

Insurance Agent's Name	Insurance Agency	Agent's Telephone Number
		( ) -

Prepared by:	Official title:	Date:

Payroll Classification Code under which you report employee's wages:

Authorized Employer's Signature:_____ Date:_____

Insurer Only

Claim Administrator's Claim Number:	Date reported to Claim Administrator:	The above information is correct with the following exceptions: ☐ (Attach extra sheets if box at right is checked)

Third Party Administrator's Name:	Claim Administrator's Address:	Insurer FEIN:

Insurer's Name:	Third Party Administrator's FEIN:

Policy Number:	Policy Effective Date:	Policy Expiration Date:

First Report of Injury

Work-Related Injury & Occupational Disease Reporting

All DNRC personnel, including EFF's, must fill out a First Report of Injury (FROI) form for every on-the-job injury. This form when submitted protects the employee's right to benefits in the event a seemingly minor injury develops into a more serious condition.

Employees – Notify the supervisor of any on-the-job injury **IMMEDIATELY**

Supervisors – Three options for submitting FROI:

1.) Fill out the FROI and fax it to: **(406) 444-1357**, Attn: Paige Tabor **within 24 hours** of the injury. Paige Tabor will check the report to verify completion and forward to Montana State Fund immediately.

2.) Contact **Paige Tabor**, DNRC, Safety Officer **(406) 444-2079** *office*; **(406) 437-2746** *cell;* **(406) 368-2398** *home,* **within 24 hours** of the injury. Inform her of all the details so she may submit the report to Montana State Fund

3.) If you do not have access to a fax machine and cannot reach Paige Tabor to give her the details to file **within 24 hours** of the injury, phone in the report to Montana State Fund directly at **(800) 332-6102, Ext 5337** for Mitzie Saltzman, Team 6.

It is the **supervisor's** responsibility to

- Report the injury to Paige Tabor within 24 hours via fax or phone ***or***
- Submit the report directly to Montana State Fund via phone within 24 hours of the injury ***and*** notify Paige Tabor that a report has been filed *as quickly as possible*.

On fire assignments, the employee's supervisor is his/her immediate supervisor at the incident. If the immediate supervisor is not a DNRC employee, the **injured employee** is then responsible to submit the FROI with the fire supervisor's signature.

Contact the home unit as soon as possible to inform the DNRC supervisor of the injury.

- A hard copy of the FROI may be found in the DNRC Fire & Aviation Management Bureau's 300 Manual or may be obtained from any DNRC area office.
- To print a copy from the MSF website go to: http://www.montanastatefund.com/wps/portal. Go to Reporting an Injury at the bottom left of the screen. Click on First Report of Injury Form. You will not be able to file online. Print the form, fill out, and **fax to Paige Tabor at (406) 444-1357**.

Helpful Hints:

- Fill out all sections, except 'Insurer Only' section, as completely and legibly as possible.
- Employee and supervisor should both sign, if available. Supervisor must sign before submitting. Submit this form within 24 hours even if employee is not available to sign, e.g., hospitalized, etc.
- DNRC's federal tax ID # is **81-0302402.**
- Use payroll classification code **9422** for firefighters.
- For 'Employer mailing address,' use the main Helena DNRC address: P.O. Box 201601, Helena, MT 59620-1601. For phone number, use a number where the supervisor can be reached.
- For 'Location of Operation,' use the employee's home unit address.
- Leave the following boxes blank:

  'Employer is a sole proprietorship, partnership, corporation, limited liability company.'
  'Injured worker is a sole proprietorship, partnership, corporation, limited liability company.'
  'Insurance Agent's name'
  'Insurance Agency'
  'Agent's Telephone Number'