RECEIVED
JAN 0 3 2005

(4) 032005 069627

MONTANA STATE FUND
P.O. Box 4759
Helena, MT 59604-4759

First Report

M.S.F. MAIL ROOM #12 Fax: 406-444-5983 Voice: 800-332-6102

Adjuster Date Stamp

Worker

Dept Code: (if applicable)

Last Name	First Name	M.I.	Date of Birth	Social Security Number
DISNEY	EVAN	A	4/17/78	517 13 7948

Home address	City	State	Postal Code
7777 STARR DRIVE	MISSOULA	MT	59802

Phone Number	Education	Gender	Marital Status	Number of Dependents
406 728-7663	☐ 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
9/18/03		/	/	/	/

Employment Status	Number of days worked per week	Wage:
☒ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer	5	☒ 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	1/3/05		☐ yes ☐ No	☐ Yes ☐ No

Accident Description

Description of Accident (Limited to 1269 characters; continue on separate sheet if necessary): CARRYING BOX OF FILES DOWN STAIRS LOST FOOTIN

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury
FELL DOWN STAIRS	RIBS, HAND, ANKLE	BROKEN/BRUISED CONTUSION	1/03/05 ± 10:30AM

Date disability began:	Date of Death:	Occupation:	Names of witnesses: 1) 2)
1/3/05		SALES	

Accident on employer's premises?	Accident address or location:	City:	State:	Postal code:
☒ Yes ☐ No	2101 MULLAN RD	MISSOULA	MT	59808

Date employer notified:	Accident reported to:	Safety equipment provided?	Safety equipment used?
1/3/05	JACK REED	☒ Yes ☐ No	☐ Yes ☒ No

Medical

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

Hospital Name	Address	State	Postal Code	Phone Number
COMMUNITY HOSPITAL-EMERGENCY	2827 FT. MISSOULA RD, MSLA	MT	59804	406 327-4080

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 fined and/or imprisoned.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.) 00-0000000
MOUNTAIN SUPPLY CO.	SAME	81-0298294

Mailing Address	City	State	Postal Code	Phone Number
2101 MULLAN ROAD	MISSOULA.	MT	59808	406 543-8255

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
	521700	☐ Yes ☒ No

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

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
ROD GABRIEL	TALBOT-CHRISS CRAWFORD AGENCY	406-728-6016

Prepared by:	Official title:	Date:
JACK REED	BRANCH MANAGER	1/3/05

Payroll Classification Code under which you report employee's wages:	Authorized Employer's Signature:	Date:
8111-00	Jack Reed	1/3/05

03-257374-3

MOUNTAIN SUPPLY CO.

2101 Mullan Road
Missoula, MT 59808
543-8255 Fax# 728-5888
800-821-1646

RECEIVED
JAN 0 3 2005
M.S.F. MAIL ROOM #12

To: STATE FUND **From:** JACK REED

Company: _____ **Company:** **Mountain Supply Co.**

Phone#: _____ **Phone#:** (406) 543-8255

Fax#: 406-444-5963 **Fax#:** (406) 728-5888

Date: 1/3/05 **Email:** msc@mountainsupply.com

Number of Pages: 3 ☐ URGENT ☐ FOR REVIEW

CC: _____ ☒ PLEASE COMMENT ☐ PLEASE REPLY

Message:

EVAN DISNEY WILL BE IN TOMORROW TO SIGN THE ATTACHED FIRST REPORT FORM AND OUR CONTROLLER WILL BE SUPPLYING THE PAYROLL INFORMATION.
WOULD IT BE POSSIBLE TO RECEIVE A CLAIM NUMBER SO IT CAN BE SUPPLIED TO COMMUNITY HOSPITAL?
PLEASE CONTACT ME IF YOU HAVE ANY QUESTIONS.
THANK YOU,
JACK REED

Montanans Proudly Building Partnerships Since 1960

COMMUNITY MEDICAL CENTER
2827 Fort Missoula Road • Missoula, MT 59804
(406) 327-4747 • www.communitymed.org

RECEIVED
JAN 0 3 2005
M S F MAIL ROOM #12

Patient Name: DISNEY, EVAN
Patient Account #: _____

You were unable to give us your complete insurance information at the time of your service. Please complete the items checked below. Please mail to the Patient Accounts Department at the above address or call our customer service representative at 406-327-4747 with the correct information. If we do not receive your insurance information within 7 days from your service you will be responsible for billing your own insurance.

03 2005 06962T

Insurance Information:

- ☐ Name of Insurance Company _____
- ☐ Policy or Certificate # _____
- ☐ Group # _____
- ☐ Subscriber Name _____
- ☐ Subscriber SS# _____
- ☐ Address of Insurance Company _____
- ☐ Copy of Your Insurance ID Card – Both Front and Back

Workers Compensation Information:

- ☐ Workers Compensation Carrier STATE FUND
- ☐ Address of Carrier PO Box 4759 HELENA MT 59604-4759
- ☐ Employer MOUNTAIN SUPPLY 2101 MULLAN RD MISSOULA MT 59808
- ☐ Case Number _____
- ☐ Date of Accident 1/3/05
- ☐ Type of Injury FELL DOWN STAIRS (POSSIBLE RIB, HAND, ANKLE INJURY)

Third Party/Private Auto Insurance:

- ☐ Name of Insurance Company _____
- ☐ Address of Insurance Company _____
- ☐ Policy Numbers _____
- ☐ Agent or Adjuster Name _____
- ☐ Telephone Number of Agent or Adjustor _____
- ☐ Policy Holders Name & Address _____

IF THERE IS AN ADDITIONAL INSURANCE YOU WOULD LIKE BILLED, PLEASE PROVIDE INFORMATION ON THE BACK OF THIS FORM.

Customer Service: 406-327-4747
Fax Number: 406-327-4545

Thank you for your time and cooperation.

8261-1D

MONTANA STATE FUND
P.O. Box 4759
Helena, MT 59604-4759

03-2005-06962-7

RECEIVED IN
JAN 05 2005
S.F. MAIL ROOM

First Report
Fax: 406-444-5963
Voice: 800-332-6102

Adjuster Date Stamp

Worker

Dept Code: (if applicable)

Last Name	First Name	M.I.	Date of Birth	Social Security Number
DISNEY	EVAN	A	4/17/78	517 13 7948

Home address	City	State	Postal Code
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Phone Number	Education	Gender	Marital Status	Number of Dependents
406 728-7663	☐ Less Than High School ☐ GED or High School Diploma ☒ Beyond High School	☒ Male ☐ Unknown ☐ Female	☒ Not Married ☐ Married ☐ Separated ☐ Unknown	0

Wages

Date Hired	Gross earnings for four pay periods preceding the injury.	1 Date / Amount	2 Date / Amount	3 Date / Amount	4 Date / Amount
9/18/03		11/12 / 800.00	11/26 / 800.00	12/10 / 805.38	12/24 / 834.75

Employment Status	Number of days worked per week	Wage:	
☒ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer	5	10.50	☒ 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:	$75.00	☒ 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	1/3/05		☒ yes ☐ No	☐ Yes ☐ No

Accident Description

Description of Accident (Limited to 1269 characters; continue on separate sheet if necessary): CARRIED BOX OF FILES DOWN STAIRS + LOST FOOTING

Cause of Injury	Part of Body	Nature of Injury	Date and Time of Injury	Date disability began	Date of Death:	Occupation:	Names of witnesses:
FELL DOWN STAIRS	RIBS, HAND, ANKLE	BROKEN/BRUISED CONTUSION	1/03/05 ± 10:30 AM	1/3/05		SALES	1) 2)

Accident on employer's premises?	Accident address or location: City	State	Postal code
☒ Yes ☐ No	2101 MULLAN RD MISSOULA	MT	59808

Date employer notified:	Accident reported to:	Safety equipment provided?	Safety equipment used?
1/3/05	JACK REED	☒ Yes ☐ No	☐ Yes ☒ No

Medical

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

Hospital Name	Address	State	Postal Code	Phone Number
COMMUNITY HOSPITAL - EMERGENCY	2827 FT. MISSOULA RD, MSLA	MT	59804	406 327-4080

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 fined and/or imprisoned.

Signature of Injured Worker or Beneficiary: Date:

Employer

Employer Name	Doing Business as:	Federal Employer Identification Number (tax I.D.)
MOUNTAIN SUPPLY CO.	SAME	00 - 0000000 81-0298294

Mailing Address	City	State	Postal Code	Phone Number
2101 MULLAN ROAD	MISSOULA	MT	59808	406 543-8255

Location of operation, if different from mailing address:	Nature of Business or SIC Code:	Self-Insured?
	521700	☐ 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?	If yes, please explain fully. Use separate sheet if you need additional space.	Was worker injured while in your employ?
☐ Yes ☒ No		☒ yes ☐ no

Insurance Agent's Name	Insurance Agency	Agent's Telephone Number
ROD GABRIEL	TALBOT-CHRISS CRAWFORD AGENCY	406-728-6016

Prepared by:	Official title	Date:
JACK REED	BRANCH MANAGER	1/3/05

Payroll Classification Code under which you report employer's wages:	Authorized Employer's Signature:	Date:
8111-00	Jack Reed	1/3/05

03-257374-3

MOUNTAIN SUPPLY CO.

2101 Mullan Road
Missoula, MT 59808
543-8255 Fax# 728-5888
800-821-1646

To: MARY Simpson
Company:
Phone#:
Fax#: 406-444-5963
Date: 1/5/05
Number of Pages: 2
CC:

From: Doug Tallent
Company: Mountain Supply Co.
Phone#: (406) 543-8255
Fax#: (406) 728-5888
Email: msc@mountainsupply.com

☐ URGENT ☐ FOR REVIEW
☐ PLEASE COMMENT ☐ PLEASE REPLY

Message:

MARY:

HERE IS THE FIRST REPORT WITH THE ADDITIONAL INFORMATION YOU REQUESTED. PLEASE CONTACT ME FOR ANY ADDITIONAL REQUEST

THANK YOU
DOUG TALLENT

Montanans Proudly Building Partnerships Since 1960

MONTANA STATEFUND

5 South Last Chance Gulch • P.O. Box 4759 • Helena, MT 59604-4759
Customer Service: 1-800-332-6102 or 406-444-6500
Fraud Hotline: 1-888-682-7463 (888-MT-CRIME)

January 05, 2005

EVAN A DISNEY
7777 STARR DRIVE
MISSOULA MT 59804

RE: First Report of Injury
Evan Disney
Claim Number - 03-2005-06962-7

Dear EVAN DISNEY:

Please read this over carefully and check it for accuracy. As I explained to you on the telephone, one of your parents or a legal guardian will also have to sign this due to your age. After you and your guardian have signed it, please return one copy, and keep one copy for your own file.

Please call if you have any questions.

Sincerely,

Lynn Lutz
Claim Adjuster
(464) 444-5961

Enclosure(s)

SF-MIS MC5515 (REV 06/04)
Injured Worker Under Age Verification

Montana Vocational Rehabilitation Programs (MVR)
Montana Department of Public Health & Human Services
AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

1-9-12

Once the information is disclosed, it may be subject to re-disclosure by the recipient and federal privacy laws or regulations may no longer protect the information. I can cancel permission to use and disclose my information at any time in writing. Permission to use and disclose alcohol and drug treatment records can be canceled by talking with my counselor. My refusal to sign this release may impact the provision of MVR services and my counselor will inform me of the impact should I choose not to sign.

To: MT State Fund Workers Comp
PO B 4759 59604
Helena MT 59604-6669

Return to: VR Counselor AF
Vocational Rehabilitation
2675 Palmer St A
Missoula, MT 59808-1700
Phone: 406 329 5400 Fax: 406 329 5420

****

Consumer: Evan Disney *Birth date:* 4/17/78

Maiden or Other Name: *Social Security #:* 517-13-7948

☑ I request and authorize to release to Montana Vocational Rehabilitation the specified information
☑ I authorize Montana Vocational Rehabilitation to release to you the specified information

The specified expiration date for this release of information is: 1/16/14. (The expiration date may not exceed 30 months from the date of signature. The expiration date is 6 months from signature if this field is left blank.)

Explanation / Purpose: Determine Eligibility

Information To Be Released: *please initial that information you wish released*

X Medical Records	____ Social Information	____ Work Evaluation
X Psychological Evaluation/Treatment	____ Academic Information	____ Employment Information
____ Psychiatric Evaluation/Treatment	____ Chemical Dependency Assessment/Treatment	
____ Social Security	____ Financial Information	

Other

X _____ 1/6/12
Consumer Signature / Approval — Date

_____ _____
*Parent or Guardian Signature / Approval — Date

_____ _____
**Witness Signature — Date

_____ _____
**Witness Signature — Date

* If consumer is a minor, signature of a parent or guardian is required.

** If unable to write his or her name, the consumer should enter an "x" or other mark. Signatures of two witnesses a required.

I request this authorization to release personal information be revoked.
Signature: _____ Date: _____

Vocational Rehabilitation is a HIPAA compliant Program of Department of Public Health and Human Servi