



Accident/Injury Information Request

**Please complete in
full and sign.**

1. General information

Employee/insured: _____ Social Security/ID # _____

Employee address: _____

Employee agency/department: _____

Name of injured person: _____ Relationship to employee: _____

2. Reason for seeking medical attention

Is this condition due to an accident, i.e. cut, fracture, sprain or strain? YES NO **If you marked NO, you may skip to the bottom of this page and sign.** If you marked YES, then provide the following information.

Briefly describe how and where accident/injury happened. _____

Date accident/injury occurred: _____ Date first treated: _____

Name of physician first consulted: _____

*WORK-RELATED AUTOMOBILE HOME OTHER

*If you marked the WORK-RELATED box, you must file the claim with Workers' Compensation.

3. Third party liability information

Please provide the following information if someone else is liable for this injury, i.e. car insurance, homeowner's insurance.

Name of company: _____

Name of policyholder: _____

Policy # _____ Phone # _____

I certify that the foregoing statements, including accompanying statements, are true and complete to the best of my knowledge. I authorize any physician, hospital, insurance company, organization or employer to release any information, including full copies of their records to Missoula County Risk and Benefits for any medical services, treatments or benefits rendered or payable to me (or my dependents). A photocopy of this authorization shall be as valid as the original.

Employee signature _____ Date _____

Patient signature (if 18 years or older) _____ Date _____