



Montana Department of
LABOR & INDUSTRY

**MONTANA DEPARTMENT
OF LABOR & INDUSTRY**
EMPLOYMENT RELATIONS DIVISION
WORKERS COMPENSATION CLAIMS
EXAMINER CERTIFICATION

P.O. Box 8011
HELENA, MONTANA 59604 -8011

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CLAIMS EXAMINER

**NEW HIRE
or
TRAINING PROGRAM
NOTIFICATION**

The undersigned hereby applies for certification to act as a Workers Compensation Claims Examiner pursuant to the provisions of 39-71-320, MCA, and ARM 24.29.811-24.29.851

_____ **New Hire** (New employee to employer or formerly hired, but separated from prior employment for a least 60 days, **not currently certified** and NO TRAINING PROGRAM). **Employee must become certified no later than 60 days after date of hire.**

_____ **Training Program** (New employee to employer and participating in Training Program provided by employer). **Training Program must be completed and employee must be certified no later than 180 days after date of hire.**

_____ **New Hire – Already Certified** (Updating Contact/Employer information).

_____ **Leaving Employment** (Updating Contact/Employer information).

1. Name _____
(Last) (First) (Middle)

2. Residence Address _____
(Street) (City) (State) (Zip)

3. Date of Birth _____ Graduation/GED Date _____ Social Security Number Last Four# _____

4. Residence/Cell Phone Number _____ Business Phone Number _____

5. Employing Firm _____ **Date of Hire:** _____
(Name)

6. Firm Address _____
(Street) (City) (State) (Zip)

7. Business Address (if different than Employer Address) _____
(Street) (City) (State) (Zip)

8. Business E-mail _____

PLEASE CHECK ONE:

USE EMPLOYER _____ OR PERSONAL _____ MAILING ADDRESS FOR THIS CERTIFICATION.

I certify that the above information is correct and true to the best of my knowledge.

Date

Signature (Electronic Signature)
