CONTINUING EDUCATION CREDITS OF WORKERS COMPENSATION CLAIMS EXAMINER CERTIFICATION
Montana Department of Labor & Industry / Employment Relations Division

NAME OF INDIVIDUAL (As on Certification: first, middle, last name) _____

MT. CERTIFICATION NUMBER (ERD) #_____ Insurance Commissioner Adjuster License# (if applicable) _____

SOCIAL SECURITY NUMBER (Last 4 #'s) _____ CERTIFICATION RENEWAL DATE _____

RESIDENCE ADDRESS (Street Address) _____ (City, State, Zip Code) _____

EMAIL ADDRESS_____ BUSINESS NAME: _____

BUSINESS MAILING ADDRESS (P.O. Box Number, City, Zip Code) _____ PHONE _____

MONTANA-APPROVED COURSES COMPLETED TO MEET REQUIREMENT
(Please attach copies of certificates of completion for each course taken)

SPONSORING ORGANIZATION (COURSE PROVIDER)	MONTANA COURSE NUMBER	COURSE TITLE	CREDIT HOURS	DATE (mm/dd/yy) COMPLETED

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

_____ _____ _____

Original Signature Print Name Date