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

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RENEWAL CERTIFICATION APPLICATION

RENEWAL FEE $75.00 To Be Included with Renewal Application (Payable to Claims Examiner Certification Program)

CLAIMS EXAMINER REPORT OF CONTINUING EDUCATION FORM MUST BE ATTACHED TO THIS RENEWAL APPLICATION

The undersigned hereby applies for a renewal of 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

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

CURRENT CERTIFICATION # _____ RENEWAL DATE: _____

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

3. Date of Birth_____ Social Security Number (Last 4 #) _____

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

5. Employing Firm _____

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

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

8. Business Email _____

9. The undersigned requests Department approval for Carry Over CE Credits _____ Yes _____ No

CARRY OVER CREDITS: _____ Hours

If there is a lapse in the Certification, carry over credits will be lost and not applicable to the new certification period.

10. On a separate sheet, please provide a statement that describes any significant change in your employment experience and places of residence during the past two (2) years. (If none please omit)

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

_____ Date

_____ Applicant's Signature

Submit Form