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 180 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)**

_____ _____

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