

Injury Codes – REQUIRED
 (See attached Injury Code Table) CASE #: _____

PLEASE CODE ONE LINE IN EACH COLUMN FOR EVERY BODY PART INJURED.

| PART OF BODY | SIDE L/R | NATURE OF INJURY | SOURCE OF INJURY | EVENT TYPE | ENVIRONMENTAL FACTORS |
|----------------------|----------------------|----------------------|----------------------|----------------------|-----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
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Employee Certification: I authorize the Division of Workers' Safety and Compensation to disclose and or obtain information about my case to or from other state agencies; insurers, group health plans, third party administrators, health maintenance organizations or similar entities. The information that may be released or obtained includes: my name, my social security number, the medical services I received and the dates of those services, the amounts charged by health care providers for my medical services, and the amount of benefits paid. This information may be needed to ensure that benefit payments are not duplicated.

The information given by me herein is true and correct. I further acknowledge that misrepresentation or fraud can lead to a civil action or criminal prosecution. By filing this report, I grant the Division of Workers' Safety & Compensation full access to any records maintained by any of my health care providers, photocopies of this authorization shall be given the same effect as the original.

Employee Signature or Employee's Representative Date Relationship to Employee

 Print **Employee** Name **EMPLOYEE SSN#** - -

Employer Certification: I am an authorized agent of the employer. The information given by me herein is true and correct. I further acknowledge that misrepresentation or fraud can lead to a civil action or criminal prosecution.

Do you believe this injury or condition is work-related? Yes No If no, please attach letter of explanation stating the disputed facts.

If yes, do you approve payment of temporary total disability benefits to which the employee may be entitled? Yes No If no, please attach letter of explanation.

Employer / Supervisor Signature Date

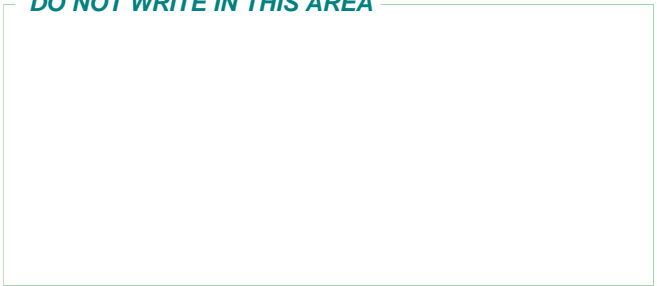
 Print **Employer / Supervisor** Name Title

WORK COMP EMPLOYER # WORK COMP ACCOUNT # PHONE #: () -

DO NOT WRITE IN THIS AREA

Mail ORIGINAL form to:

Wyoming Workers' Safety & Compensation Division
PO Box 20207
Cheyenne, WY 82003 - 7005



IMPORTANT: To assist in processing this report of injury in a timely manner, please return the ORIGINAL form to the division.

For general claims information call (307)777-7441

To order forms please call the mail room at (307) 777-3546 or (307) 777-6375