WYOMING REPORT OF INJURY

Workers' Safety & Compensation 307-777-7441 **CASE #:** _____

Please use ***BLACK*** ink. Do not cross zeros or sevens.

EMPLOYER INFORMATION

BUSINESS NAME

WORK COMP EMPLOYER #

ADDRESS

WORK COMP ACCOUNT #

CITY ST ZIP PHONE #

TYPE OF BUSINESS _____

EMPLOYEE INFORMATION

LAST NAME FIRST NAME MI

MAILING ADDRESS

CITY ST ZIP PHONE #

PHYSICAL ADDRESS

CITY ST ZIP DATE HIRED STATE HIRED

US CITIZEN? Yes ☐ No ☐ IF NO, INS#

SSN# SEX: M ☐ F ☐

DATE OF BIRTH MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ NUMBER OF DEPENDENTS

DRIVER LICENSE # ST EDUCATION: HIGHEST GRADE COMPLETED

WAGE INFORMATION

WAGE RATE $ PER: HOUR ☐ DAY ☐ WEEK ☐ ✔ MONTH ☐ HOURS WORKED PER DAY # OF DAYS WORKED PER WEEK

OT HOURS PER WEEK PAID IN FULL FOR THE DAY OF INJURY? Yes ☐ No ☐ DO YOU HAVE MORE THAN ONE PAYING JOB? Yes ☐ No ☐

INJURY INFORMATION

DATE OF INJURY TIME OF INJURY AM ☐ PM ☐ IF FATALITY, DATE OF DEATH

SHIFT BEGAN AM ☐ PM ☐ SHIFT ENDED AM ☐ PM ☐ DATE EMPLOYER NOTIFIED

PERSON CONTACTED CONTACT PHONE #

EMPLOYEE JOB TITLE EMPLOYEE STATUS: OWNER ☐ CORPORATE OFFICER ☐ PARTNER ☐ INDEPENDENT CONTRACTOR ☐

CHOOSE TYPE OF EMPLOYEE: R - REGULAR V - VOLUNTEER I - INMATE O - OTHER

TIME LOST FROM WORK? Yes ☐ No ☐ DATE LOST TIME BEGAN DATE RETURN TO WORK

DESCRIBE THE ACCIDENT/ INJURY: (ATTACH SEPARATE SHEET IF NEEDED AND EXPLAIN WHICH SIDE AND BODY PART HAS BEEN INJURED)

MACHINE/PRODUCT FAILURE OR VEHICLE ACCIDENT? Yes No DID INJURY OCCUR ON EMPLOYER PREMISES? Yes ☐ No ☐

ACCIDENT ADDRESS _____

CITY ST COUNTY

WITNESS NAME WITNESS PHONE #

HAS THIS BODY PART(S) BEEN INJURED PREVIOUSLY? Yes ☐ No ☐ EXPLAIN: (ATTACH SHEET IF NEEDED) _____

WAS THE PRIOR INJURY WORKERS' COMP? Yes ☐ No ☐ IF YES, IN WHAT STATE? DATE OF PRIOR INJURY

TREATING HEALTH CARE PROVIDER

ADDRESS PHYSICIAN PHONE #

CITY ST ZIP DATE OF INITIAL EXAM

IMPORTANT: PLEASE COMPLETE THE BACKSIDE OF THIS FORM.

NOTE: This report of injury is not a claim for benefits.
Benefits must be filed on separate forms.
An incomplete form may be returned and will delay case processing.

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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

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

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