

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 _____
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 MM / DD / YY STATE HIRED _____
US CITIZEN? Yes No IF NO, INS# _____ SSN# _____ - _____ - _____ SEX: M F
DATE OF BIRTH MM / DD / YY 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 MM / DD / YY TIME OF INJURY _____ : _____ AM PM IF FATALITY, DATE OF DEATH MM / DD / YY
SHIFT BEGAN _____ : _____ AM PM SHIFT ENDED _____ : _____ AM PM DATE EMPLOYER NOTIFIED MM / DD / YY
PERSON CONTACTED _____ CONTACT PHONE # (_____) _____ - _____
INJURED WORKER JOB TITLE _____ 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 MM / DD / YY DATE RETURN TO WORK MM / DD / YY

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 MM / DD / YY
TREATING HEALTH CARE PROVIDER _____
ADDRESS _____ PHYSICIAN PHONE # (_____) _____ - _____
CITY _____ ST _____ ZIP _____ DATE OF INITIAL EXAM MM / DD / YY

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.

INJRPT

REVISED 06/06

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"/>
<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"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Employee Release: 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.

I agree this release shall remain in full effect until revoked by me in writing.

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 Unsure
 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 Unsure
 If no, please attach letter of explanation.

Drug or alcohol test performed on date of injury? Yes No Unsure

Employer / Supervisor Signature Date

 Print **Employer / Supervisor Name** Title

WORK COMP EMPLOYER # Business Name _____ PHONE #: () _____

Mail ORIGINAL form to:

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

DO NOT WRITE IN THIS AREA

IMPORTANT: For general claims information call (307)777-7441
 To order forms please call the mail room at (307) 777-6375