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 | STATE HIRED

US CITIZEN? Yes ☐ No ☐ | IF NO, INS# | SSN# | SEX: M ☐ F ☐

DATE OF BIRTH | MARITAL STATUS: SINGLE ☐ MARRIED ☐ _____ (Spouse first name) 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 #

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 | DATE RETURN TO WORK

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

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 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 Medicare and Medicaid service centers. 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# _____

If you are a Medicare Beneficiary, you are required to provide your HICN assigned by the Social Security Administration:

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.

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 #: ( ) _____

DO NOT WRITE IN THIS AREA

Mail ORIGINAL form to:

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

IMPORTANT: **For general claims information visit http://doe.wyo.gov**

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Nature of Injury Codes

Code	Injury	Code	Injury
01	Amputation	02	Asphyxia
03	Bruise, contusion, abrasion	04	Burn (chemical)
05	Burn or scald (heat)	06	Concussion
07	Cut or laceration	08	Dermatitis
09	Dislocation	10	Electric Shock
11	Foreign body in eye	12	Fracture
13	Freezing or frost bite	14	Hearing loss
15	Heat exhaustion	16	Hernia
17	Poisoning (systemic)	18	Puncture
19	Radiation effect	20	Strain or sprain
21	Other, please describe	22	Cancer
23	Industrial disease	24	Mental disorder
25	Coronary condition	26	Disfigurement

Source of Injury Codes

Code	Injury	Code	Injury
01	Aircraft	02	Air Pressure
03	Animal, insect, bird, reptile, fish	04	Boat
05	Bodily motion	06	Boiler pressure
07	Boxes, barrels, etc.	08	Buildings, structures
09	Chemical liquids or vapors	10	Cleaning compound
11	Cold (environmental or mechanical	12	Dirt, sand, stone
13	Drugs or Alcohol	14	Dust, particles, chips
15	Electrical apparatus or wiring	16	Fire or smoke
17	Food	18	Furniture or furnishings
19	Gases	20	Glass
21	Hand tool (powered)	22	Hand tool (manual)
23	Heat (environmental or mechanical	24	Hoisting apparatus
25	Ladder	26	Machine
27	Materials handling equipment	28	Metal products
29	Motor vehicle (highway)	30	Motor vehicle (industrial)
31	Motorcycle	32	Windstorm, lightning, etc.
33	Firearm	34	Person
35	Petroleum products	36	Pump or Prime motor
37	Radiation	38	Train or railroad
39	Vegetation	40	Waste Products
41	Water	42	Working surface
43	Other, please describe	44	Fumes
45	Mists	46	Vibration
47	Noise	48	Biological agent

Part of Body Codes

Code	Injury	Code	Injury
01	Abdomen	02	Arm(s) Multiple
20 36 37	Back Neck Mid-Back (Thoracic) Low-Back (Lumbar)	04	Body system
05	Chest	06	Ear(s)
07	Elbow	08	Eye(s)
09	Face	10	Finger(s)
11	Foot, toe(s), or ankle	12	Hand(s)
13	Head	14	Hip(s)
15	Knee(s)	16	Leg(s)
17	Lower arm(s)	18	Lower leg(s)
19	Multiple	20	Neck (Cervical)
21	Shoulder(s)	22	Upper arm(s)
23	Upper Leg(s)	24	Wrist(s)
25	Blood	26	Kidney
27	Liver	28	Lung
29	Nervous system	30	Reproduction system
31	Other body system, please describe	32	Thumb
33	Groin	34	Great Toe
35	Heart	36	Mid-Back (Thoracic)
37	Low Back (Lumbar)	38	Pelvis
39	Ribs	40	Teeth
41	Tailbone (coccyx)	42	Buttocks

Event Type Codes

Code	Injury	Code	Injury
01	Struck by	02	Caught in or between
03	Bite, sting, or scratch	04	Fall (same level)
05	Fall (from elevation)	06	Struck against
07	Rubbed or abraded	08	Inhalation
09	Ingestion	10	Absorption
11	Repeated motion or pressure	12	Cardio-vascular, respiratory system
13	Shock	14	Other, please describe
15	Lifting		

Environmental Factor Codes

Code	Injury	Code	Injury
01	Pinch point action	02	Catch point or puncture action
03	Shear point action	04	Squeeze point action
05	Flying object action	06	Overhead moving and/or falling object
07	Gas, vapor, dust, etc.	08	Materials handling equipment or method
09	Chemical action/reaction exposure	10	Flammable liquid or solid exposure
11	Temperature above or below tolerance level	12	Radiation condition
13	Working surface or facility layout condition	14	Illumination
15	Over pressure or under pressure condition	16	Sound level
17	Weather, earthquake, etc. condition	18	Other, please describe