WYOMING REPORT OF INJURY

EMPLOYER INFORMATION	Please use <u>BLACK</u> ink. Do not cross zeros or sevens.
BUSINESS NAME	WORK COMP EMPLOYER #
ADDRESS	
CITY	\$T : ZIP : PHONE;
EMPLOYEE INFORMATION LAST NAME	BUSINESS
MAILING ADDRESS	
CITY	ST ZIP PHONE#
PHYSICAL ADDRESS	
СПТУ	ST ZIP DATE STATE HIRED STATE HIRED
US CITIZEN? Yes No	IF NO, INS# SEX: M F
DATE OF BIRTH DRIVER LICENSE # WAGE INFORMATION	MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED NUMBER OF DEPENDENTS Spouse first name ST EDUCATION: HIGHEST GRADE COMPLETED
WAGE RATE	PER: HOUR DAY WEEK MONTH HOURS WORKED # OF DAYS WORKED PER WEEK N FULL FOR THE DAY OF INJURY? Yes No DO YOU HAVE MORE THAN ONE PAYING JOB? Yes No DO YOU HAVE MORE THAN ONE PAYING JOB?
INJURY INFORMATION	
DATE OF INJURY SHIFT BEGAN PERSON CONTACTED INJURED WORKER JOB TITLE	TIME OF INJURY AM PM DATE OF DEATH AM PM DATE EMPLOYER NOTIFIED CONTACT PHONE # STATUS: OWNER COPPORATE PARTNER INDEPENDENT CONTRACTOR
CHOOSE R - REGULAR TYPE OF V - VOLUNTEER TYPE OF I - INMATE EMPLOYEE: 0 - OTHER	TIME LOST Pas No DATE LOST 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 EMPLOYE	R PREMISES? Yes No ACCIDENT ADDRESS:
CITY WITNESS NAME HAS THIS BODY PART(S) BEEN IN.	ST COUNTY WITNESS PHONE # URED PREVIOUSLY? Yes No FXPLAIN: (ATTACH SHEFT IF NEEDED)
WAS THE PRIOR INJURY WORKER	D FYES IN
TREATING HEALTH	
CARE PROVIDER ADDRESS	PHYSICIAN PHONE#
CITY	ST ZIP DATE OF INITIAL EXAM
••	IMPORTANT: PLEASE COMPLETE THE BACKSIDE OF THIS FORM.

INJRPT REVISED 11/09 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.

Injury Codes – REQUIRED (See attached Injury Code Table) CASE #: PLEASE CODE ONE LINE IN EACH COLUMN FOR EVERY BODY PART INJURED.

1	N.
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The information given by me herein is true and correct. I further acknowledge that misrepresentation or fraud can lead to a civil stion or criminal prosecution. By filing this report, I grant the Division of Workers' Safety & Compensation full access to any cords maintained by any of my health care providers, photocopies of this authorization shall be given the same effect as e original. **Begin and the same effect as engine in full effect until revoked by me in writing.** **Bemployee Signature or Employee's Representative	PART OF BODY	SIDE L/R	NATURE OF INJURY	SOURCE OF INJURY	EVENT TYPE	ENVIRONMENTAL FACTORS
Imployee Release: I authorize the Division of Workers' Safety and Compensation to disclose and or obtain information about misse to or from other state agencies; insurers, group health plans, third party administrators, health maintenance organizations (Medican and Medical service) centers. The information lates of those services, the amounts charged by health care providers or my medical services, and the amount of benefits paid. This information may be needed to ensure that benefit payments are of 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 cords maintained by any of my health care providers, photocopies of this authorization shall be given the same effect as a criginal. Improve this release shall remain in full effect until revoked by me in writing. Employee Signature or Employee's Representative Date Print Employee Name For are a Medicare Beneficiary, you are required to provide your MCN assigned by the Social Security Administration. Employer Certification: I am an authorized agent of the employer. The information given by me herein is true an 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 Unawa If no, please attach letter of explanation stating the disputed facts. Drug or alcohol test performed on date of Ves No Unawa Employer / Supervisor Signature Date Print Employer / Supervisor Name Print Employer / Supervisor Name Supervisor Safety & Compensation Division PO Box 20207 Cheyenne, WY 82003 - 7005			•		· :	
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Set to or from other state agencies; insurers, group health plans, third party administrators, health maintenance organizations Medicaris arotive centers. The information that may be released or obtained includes ray name, my social curity number, the medical services is received and the dates of those services, the amounts charged by health care providers my medical services, and the amount of benefits paid. This information may be neceded to ensure that benefit payments are it duplicated. It is information given by me herein is true and correct. I further acknowledge that misrepresentation or fraud can lead to a civil cition or criminal prosecution. By filing this report, I grant the Division of Workers' Safety & Compensation full access to any cords maintained by any of my health care providers, photocopies of this authorization shall be given the same effect as e original. Igree 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 Fint Employee Name Fint Employee Certification: I am an authorized agent of the employer. The information given by me herein is true an 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? Fin on, please attach letter of explanation stating the disputed facts. Drug or alcohol test performed on date of Yes No Unsure Title Print Employer / Supervisor Signature Date Mail ORIGINAL form to: Mail ORIGINAL form to: You Do NOT WRITE IN THIS AREA Mail ORIGINAL form to: You Boundary & 2003 - 7005				·		
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Employee Signature or Employee's Representative Date Relationship to Employee EMPLOYEE SSN# Print Employee Name For 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 an 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? Yee No Undeare If no, please attach letter of explanation stating the disputed facts. Drug or alcohol test performed on date of Yes No Unsure Date Print Employer / Supervisor Signature Date Print Employer / Supervisor Name Fittle PHONE #: () Mail ORIGINAL form to: Yoming Workers' Safety & Compensation Division PO Box 20207 Cheyenne, WY 82003 - 7005	ction or criminal proce	acution Rv	filing this report. Lara	nt the Division of Worl	kers' Satety & C	compensation full access to any
Print Employee Name Sand Print Employee Name From 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 an 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? If no, please attach letter of explanation stating the disputed facts. Drug or alcohol test performed on date of Yes No Unesure Injury? Employer / Supervisor Signature Date Print Employer / Supervisor Name Fittle DORK COMP Busines Name PHONE 8: (agree this release sha	III remain in	full effect until revoke	d by me in writing.		
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Employer / Supervisor Signature Print Employer / Supervisor Name Date Title DRIC COMP PHONE #: () Mail ORIGINAL form to: Yoming Workers' Safety & Compensation Division PO Box 20207 Cheyenne, WY 82003 - 7005	Do you believe this If no, please attach	injury or co letter of ex	lge that misrepresen andition is work-related planation stating the c	itation or fraud can l d? Yes □ No □ Uns lisputed facts.	ead to a civil a	n given by me herein is true and action or criminal prosecution.
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IMPORTANT: For general claims information visit http://doe.wyo.gov	yoming Workers	s' Safety PO Box	& Compensation 20207	Division		
IMPORTANT: For general claims information visit http://doe.wyo.gov						
	Г	IMPOR	TANT: For general	claims information	visit http://doc	e.wyo.gov
		01	.,,,,,,,			

REVISED 11/09

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

Fart of Body Codes				
Code	Injury	Code	Injury	
01	Abdomen	02	Arm(s) Multiple	
	Back	04	Body system	
20	Neck			
36	Mid-Back (Thoracic)			
37	Low-Back (Lumbar)			
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	32	Thumb	
	describe	24	Const Top	
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

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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		