Department of Workforce Services
Division of Workers' Compensation
Report of Injury

EMPLOYER INFORMATION Please use **BLACK** ink. Do not cross zeros or sevens Claim Number: _____

BUSINESS NAME			WORK COMP EMPLOYER #
ADDRESS			
CITY	STATE	ZIP	PHONE
TAX ID TYPE (FEIN OR SSN)	TAX ID NUMBER		NATURE OF BUSINESS (MANUFACTURING, ETC.)

EMPLOYEE INFORMATION

LAST NAME	FIRST NAME		MI
MAILING ADDRESS	CITY	STATE	ZIP
PHYSICAL ADDRESS (IF DIFFERENT FROM MAILING ADDRESS	CITY	STATE	ZIP
PHONE (WITH AREA CODE)	EMAIL ADDRESS		
DATE OF BIRTH	DATE OF HIRE	STATE OF HIRE	
SOCIAL SECURITY NUMBER	US CITIZEN? ☐ YES ☐ NO	IF NO, PROVIDE INS#	
SEX ☐ FEMALE ☐ MALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED		

INJURY INFORMATION

DATE OF INJURY	TIME OF INJURY ☐ AM ☐ PM	TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM	TIME EMPLOYEE ENDED WORK ☐ AM ☐ PM
DATE EMPLOYER WAS NOTIFIED OF INJURY	LAST DAY OF WORK AFTER INJURY	DATE OF RETURN TO WORK	EMPLOYEES OCCUPATION (JOB TITLE) WHEN INJURED
TYPE OF EMPLOYEE ☐ REGULAR ☐ VOLUNTEER ☐ INMATE ☐ OTHER		EMPLOYEE STATUS ☐ OWNER ☐ PARTNER ☐ CORPORATE OFFICER ☐ INDEPENDENT CONTRACTOR	
NAME OF PERSON CONTACTED		CONTACT PHONE NUMBER	DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO
ADDRESS OR LOCATION OF ACCIDENT	CITY	COUNTY	STATE / ZIP
FATALITY ☐ YES ☐ NO	IF YES, WHAT IS THE DATE OF DEATH?	DID INJURY RESULT IN MEDICAL TREATMENT OR LOST TIME FROM WORK? ☐ MEDICAL TREATMENT ☐ LOST TIME FROM WORK	
NAME OF PHYSICIAN OR HEALTH CARE PROFESSIONAL	ADDRESS / CITY / STATE / ZIP CODE		DATE OF INITIAL EXAM

LIST ALL BODY PARTS AND LOCATION OF INJURY (LOCATION BEING THE FOLLOWING: RIGHT, LEFT, BI-LATERAL, MIDDLE, LOWER, UPPER OR UNKNOWN)

PRIMARY BODY PART:	LOCATION:		
HAS THIS BODY PART BEEN PREVIOUSLY INJURED? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN		
WAS PRIOR INJURY WORKERS COMP? ☐ YES ☐ NO	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?	
SECONDARY BODY PART:	LOCATION:		
HAS THIS BODY PART BEEN PREVIOUSLY INJURED? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN		
WAS PRIOR INJURY WORKERS COMP? ☐ YES ☐ NO	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?	

LIST ADDITIONAL BODY PARTS AND LOCATIONS BELOW:

BODY PART:	LOCATION:
BODY PART:	LOCATION:
BODY PART:	LOCATION:

IMPORTANT: PLEASE COMPLETE THE BACKSIDE OF THIS FORM

Claim Number: _____

JOB DESCRIPTION

INJURED WORKER'S DETAILED JOB TITLE AT TIME OF INJURY. (For example: Civil Engineer, not just Engineer; RN or LPN, not just Nurse; Custodian or General Repairs, not just Maintenance)

WHAT WERE THE TYPICAL DUTIES OF THE INJURED WORKER'S JOB AT THE TIME OF INJURY? (For example: operating heavy equipment, mopping floor, hanging drywall, welding, doing data entry)

CAUSE OF ACCIDENT

WHAT HAPPENED? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, employee fell 20 feet:; "Employee was sprayed with chlorine when gasket broke during replacement".

WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? Examples: "concrete floor"; "chlorine", "radial arm saw". If this question does not apply to the incident, leave it blank.

WHAT WAS THE EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURED? Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing material", "spraying chlorine from hand sprayer", "daily computer key-entry".

WAGE INFORMATION

EMPLOYEE PAID ☐ HOUR ☐ DAY ☐ WEEK ☐ MONTH ☐ YEAR ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ OTHER		**IF HOURLY, WHAT IS THE RATE PER HOUR?**
IF NOT PAID HOURLY, WHAT IS THE EMPLOYEE'S PAY RATE	**HOURS WORKED PER DAY**	**NUMBER OF DAYS WORKED PER WEEK**
IS EMPLOYEE AUTHORIZED OVERTIME? ☐ YES ☐ NO	**NUMBER OF OVERTIME HOURS WORKED**	**EMPLOYEE PAID FOR THE DATE OF ACCIDENT?** ☐ YES ☐ NO
DOES THE EMPLOYEE HAVE MORE THAN ONE JOB? IF SO, STATE NAME OF EMPLOYER	**PROVIDE PHONE NUMBER OF THE ADDITIONAL EMPLOYER**	

Employee Release: I authorize the Division of Workers' 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 payment are not duplicated. The information given by me herein is true and correct. I agree this release shall remain in full effect until revoked by me in writing. Photocopies of this authorization shall be given the same effect as the original. I further acknowledge that misrepresentation or fraud can lead to a civil action and/or criminal prosecution.

EMPLOYEE SIGNATURE OR EMPLOYEE'S REPRESENTATIVE _____ TODAY'S DATE _____ RELATIONSHIP TO EMPLOYEE _____

PRINT EMPLOYEE OR REPRESENTATIVE 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 belive 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

EMPLOYER / SUPERVISORY SIGNATURE _____ DATE _____

PRINT EMPLOYER / SUPERVISOR NAME _____ TITLE _____

WORK COMP EMPLOYER # _____ BUSINESS NAME _____ PHONE #: _____

MAIL ORIGINAL TO:

Division of Workers' Compensation
PO Box 20207
Cheyenne, WY 82003-7005

IMPORTANT: For General information visit www.wyomingworkforce.org or phone (307) 777-7441

DO NOT WRITE IN THIS AREA

INJRPT
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