

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 <input type="checkbox"/>	No <input type="checkbox"/>	DO YOU HAVE MORE THAN ONE PAYING JOB?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

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

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.

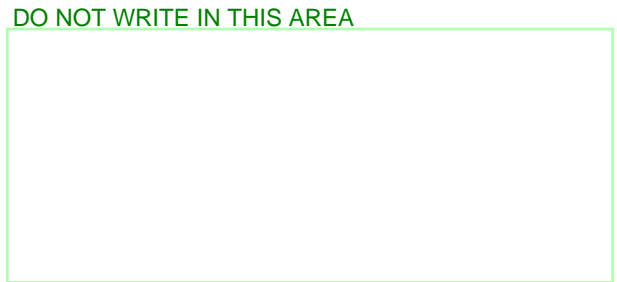
Do you believe this injury or condition is work-related? Yes No Unsure
 If no, please attach letter of explanation stating the disputed facts. If yes, do you approve payment of temporary total disability benefits to which the employee may be entitled? Yes No Unsure
 If no, please attach letter of explanation.

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



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

**WYOMING WORKERS' SAFETY AND COMPENSATION
INJURY REPORT CODE TABLES**

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 frostbite	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	Back	04	Body system
36	Neck		
37	Mid-Back (Thoracic)		
	Low Back (Lumbar)		
05	Chest	06	Ear(s)
07	Elbows	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 legs(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	Reproductive 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