



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? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF NO, PROVIDE INS#	
SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			

**INJURY INFORMATION**

DATE OF INJURY	TIME OF INJURY <input type="checkbox"/> AM <input type="checkbox"/> PM	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM	TIME EMPLOYEE ENDED WORK <input type="checkbox"/> AM <input type="checkbox"/> 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 <input type="checkbox"/> REGULAR <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> INMATE <input type="checkbox"/> OTHER		EMPLOYEE STATUS <input type="checkbox"/> OWNER <input type="checkbox"/> PARTNER <input type="checkbox"/> CORPORATE OFFICER <input type="checkbox"/> INDEPENDENT CONTRACTOR		
NAME OF PERSON CONTACTED		CONTACT PHONE NUMBER	DID INJURY OCCUR ON EMPLOYER PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
ADDRESS OR LOCATION OF ACCIDENT		CITY	COUNTY	STATE ZIP
FATALITY <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, WHAT IS THE DATE OF DEATH?	DID INJURY RESULT IN MEDICAL TREATMENT OR LOST TIME FROM WORK? <input type="checkbox"/> MEDICAL TREATMENT <input type="checkbox"/> 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 (SIDE OF BODY: RIGHT, LEFT, BI-LATERAL, MIDDLE, LOWER, UPPER OR UNKNOWN)		
PRIMARY BODY PART:		SIDE OF BODY:
HAS THIS BODY PART BEEN PREVIOUSLY INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE EXPLAIN	
WAS PRIOR INJURY WORKERS COMP? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?
SECONDARY BODY PART:		SIDE OF BODY:
HAS THIS BODY PART BEEN PREVIOUSLY INJURED? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE EXPLAIN	
WAS PRIOR INJURY WORKERS COMP? <input type="checkbox"/> YES <input type="checkbox"/> NO	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?
LIST ADDITIONAL BODY PARTS AND LOCATIONS BELOW:		
BODY PART:		SIDE OF BODY:
BODY PART:		SIDE OF BODY:
BODY PART:		SIDE OF BODY:

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 OCCURRED?** Describe the activity as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing aladder while carrying roofing material", "spraying chlorine from hand sprayer", "daily computer key-entry".

**WAGE INFORMATION**

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

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#	<div style="border: 1px solid black; width: 150px; height: 20px;"></div>

**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 a 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 #: _____
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**MAIL ORIGINAL TO:**

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

**IMPORTANT:** For General information  
visit [www.wyomingworkforce.org](http://www.wyomingworkforce.org) or  
phone (307) 777-7441

DO NOT WRITE IN THIS AREA