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 #
City of Cheyenne			3717
ADDRESS			
2101 O'Neil Avenue LOC#			
CITY	**STATE**	**ZIP**	**PHONE**
Cheyenne	WY	82001	(307) 638-4335
TAX ID TYPE (FEIN OR SSN)	**TAX ID NUMBER**		**NATURE OF BUSINESS (MANUFACTURING, ETC.)**
FEIN	836000050		Government

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?	IF NO, PROVIDE INS#
	☐ YES ☐ NO	

SEX	MARITAL STATUS
☐ FEMALE ☐ MALE	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

INJURY INFORMATION

DATE OF INJURY	TIME OF INJURY	TIME EMPLOYEE BEGAN WORK	TIME EMPLOYEE ENDED WORK
	☐ AM ☐ PM	☐ AM ☐ PM	☐ 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	EMPLOYEE STATUS
☐ REGULAR ☐ VOLUNTEER ☐ INMATE ☐ OTHER	☐ 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	IF YES, WHAT IS THE DATE OF DEATH?	DID INJURY RESULT IN MEDICAL TREATMENT OR LOST TIME FROM WORK?
☐ YES ☐ NO		☐ 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 (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?	IF YES, PLEASE EXPLAIN
☐ YES ☐ NO	

WAS PRIOR INJURY WORKERS COMP?	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?
☐ YES ☐ NO		

SECONDARY BODY PART:	SIDE OF BODY:

HAS THIS BODY PART BEEN PREVIOUSLY INJURED?	IF YES, PLEASE EXPLAIN
☐ YES ☐ NO	

WAS PRIOR INJURY WORKERS COMP?	WHAT STATE DID THE PRIOR INJURY OCCUR?	DATE PRIOR INJURY OCCURRED?
☐ YES ☐ NO		

LIST ADDITIONAL BODY PARTS AND LOCATIONS BELOW:

BODY PART:	SIDE OF BODY:
BODY PART:	**SIDE OF BODY:**
BODY PART:	**SIDE OF BODY:**

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 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

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, and any of my treating health care providers including pharmaceutical providers, past or present. 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 or MBI 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 # 3717 BUSINESS NAME City of Cheyenne PHONE #: _____

MAIL ORIGINAL TO:
Division of Workers' Compensation
PO Box 20207
Cheyenne, WY 82003-7005

EMAIL TO:
dws-wcintake@wyo.gov

IMPORTANT: For General information visit www.wyomingworkforce.org
Phone (307) 777-7441
Fax (307) 777-6552

DO NOT WRITE IN THIS AREA

INJRPT
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