# WYOMING
# WORKERS' COMPENSATION
# ACT

Your employer may have qualified with the Workers' Safety and Compensation Division for the coverage of injuries arising out of and in the course of employment, while at work on or about the premises occupied, used or controlled by the employer. This coverage is for extrahazardous industries and occupations only if the employer has elected to cover non-extrahazardous.

## In the event of a work related injury:

1. Notify your employer how and when you were injured within seventy-two (72) hours of the incident.

2. Submit a written report of your injury to Wyoming Workers' Safety and Compensation within 10 days of the incident. You must complete and sign the "Wyoming Report of Injury" form. If your employer does not have any forms, call (307) 777-7441, or contact your nearest Wyoming Workforce Center, for information on how or where to obtain an injury report form.

3. Submit the form to a local Workers' Compensation office or representative, or mail it to:

Wyoming Workers' Safety and Compensation
P.O. Box 20207
Cheyenne, WY 82002

The filing of an injury report is not a claim for lost wages or any other workers' compensation benefit. You must apply for benefits. To obtain the appropriate application form, contact Workers' Safety and Compensation. For more detailed information or assistance concerning benefits and procedures, call the Wyoming Workers' Safety and Compensation Division at (307) 777-7441 or visit http://doe.state.wy.us

# WYOMING WORK INJURY REPORTING PROCEDURES

This Claim Kit is provided for your use in reporting all employee job related injuries. Copy the forms as needed.

## Employer's First Report of Injury (FROI)

This form, numbered INJRPT (11-09), must be completed at the time of the injury and/or immediately upon the employer's knowledge of the injury. The original form should be immediately mailed, faxed or e-mailed to Berkley Industrial Comp. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records).

## Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the First Report of Injury. Maintain a copy for your records. If you utilize another version of a Supervisor's Report, it may be substituted for this form but please send it to us with the First Report of Injury.

## Wage Statement

The Wage Information section of the Report of Injury form must be completed on any case where it is anticipated that the injured employee might lose work beyond the waiting period of more than three (3) days. The State requires reporting of gross hourly wages and overtime will be considered if verification is received from the employer. We may inquire about wages for a similar employee of the same class and grade. If there are weeks with no wages, please explain the reason by coding as follows:
V= Vacation I= Illness L= Lay off P= Personal leave O= Other
If you have any questions, feel free to contact the claim department to assist you.

**Please do not hold the First Report of Injury for completion of the wage statement.**

## Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. Equally important, you must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

## Mandatory Poster

The Division of Workers' Compensation poster must be displayed in your personnel office (if there is one) and in prominent places where employees will see it.

# *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: |

**INJRPT**
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**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**
Revised 11/11

# WAGE STATEMENT

In order to determine with accuracy, the average weekly wages in accordance with the provisions of the Workmen's Compensation Law, please fill out and return.

This is to certify that I _____ am the _____
(Name of Person Certifying) (Name of Office or Position Held)

of _____ of _____
(Name of Employer) (Number, Street, City, Town)

employer of _____ injured on or about _____, _____
(Name of Injured Person) (Month, Day, Year)

**"A"** I have examined the payroll of said employer and the following table shows the days worked and the wages earned by said _____ employed as a _____ during the period stated therein.

**"B"** I have examined the payroll of said employer and find that _____ the injured employee, did not work for said employer a substantial portion of the year before the accident.

The following table shows the days worked and the wages earned by _____ another employee of the same class employed by the same employer who did work a substantial part of such year in the same or similar employment.

Official Position _____ Signed By _____

| | WEEK ENDING | | | Days Worked | Amount Paid Including Overtime | | WEEK ENDING | | | Days Worked | Amount Paid Including Overtime |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Month | Day | Year | | | | Month | Day | Year | | |
| 1 | | | | | | 27 | | | | | |
| 2 | | | | | | 28 | | | | | |
| 3 | | | | | | 29 | | | | | |
| 4 | | | | | | 30 | | | | | |
| 5 | | | | | | 31 | | | | | |
| 6 | | | | | | 32 | | | | | |
| 7 | | | | | | 33 | | | | | |
| 8 | | | | | | 34 | | | | | |
| 9 | | | | | | 35 | | | | | |
| 10 | | | | | | 36 | | | | | |
| 11 | | | | | | 37 | | | | | |
| 12 | | | | | | 38 | | | | | |
| 13 | | | | | | 39 | | | | | |
| 14 | | | | | | 40 | | | | | |
| 15 | | | | | | 41 | | | | | |
| 16 | | | | | | 42 | | | | | |
| 17 | | | | | | 43 | | | | | |
| 18 | | | | | | 44 | | | | | |
| 19 | | | | | | 45 | | | | | |
| 20 | | | | | | 46 | | | | | |
| 21 | | | | | | 47 | | | | | |
| 22 | | | | | | 48 | | | | | |
| 23 | | | | | | 49 | | | | | |
| 24 | | | | | | 50 | | | | | |
| 25 | | | | | | 51 | | | | | |
| 26 | | | | | | 52 | | | | | |
| | | | TOTAL PAID | | | | | | TOTAL PAID | | |
| | | | | | | | | | TOTAL GROSS | | |