IMPORTANT INFORMATION FOR INJURED UW EMPLOYEES AND UW SUPERVISORS: PROCEDURES TO FOLLOW IN THE EVENT OF A WORK-RELATED INJURY

EMPLOYEE RESPONSIBILITIES:

1. All injuries must be reported immediately by the injured employee to his or her supervisor.
2. Seek medical attention if necessary. Urgent care facilities in Laramie.
   Grand Avenue Urgent Care, 3236 Grand Ave - (307) 760-8602
   BestMed Urgent Care, 3810 Grand Ave - (307) 721-1794
   Convenient Care Clinic, located in Ivinson Memorial Hospital 255 N 30th St (307) 755-4540

   Their service is typically quicker and less expensive than the emergency room, so employees are encouraged to consider that option. For employees who are working outside of Laramie, and experience a work injury, please seek medical attention at the nearest appropriate health care provider.

   Advise the health care provider that you are employed by UW and that you were injured while on the job. If you are asked for a case or claim number, explain that it will be issued by the Wyoming Workers' Compensation office (refer to #3 below). **Take the UW Work-Related Injury Follow-up Form with you to your appointment (it is located at the end of these instructions). Send this completed form to David Heath (daheath@uwyo.edu) in Human Resources.**

   If you need to get a prescription filled, you may contact the U.W. Workers' Compensation Coordinator about ordering it without a case number (and not paying for it when it is filled).

3. **Notify** your supervisor of the injury **immediately**. You are required to complete the **Wyoming Employee Report of Injury** as soon as possible and be sure to include a description of what you were doing when the injury occurred (please be specific). Sign the Employee Certification section. The form may be completed electronically (must be printed and signed) or on paper. **Give completed form to your supervisor or other person authorized by your department to sign the Employer Certification.** If your supervisor is not available, please go ahead and submit the form to Human Resources so the processing will not be delayed. **DO not wait to turn in the form.** Call David Heath is you need assistance.

4. The completed Employee Report of Injury must be returned to Human Resources in Hill Hall, Room 343. **DO NOT** send it to the Workers' Compensation Division in Cheyenne. After your report is processed, the State of Wyoming Workers' Compensation Analyst will contact you by phone or mail with your case number. **It is your responsibility to contact the medical providers that treated you for this injury to provide them with the Workers' Compensation Claim number in order so they are able to bill them directly.**

5. **Ask for a written note stating whether you are able to return to work. The note must clearly indicate if you are returning to full work duties (no restrictions), if you are returning to work with partial work duties (restrictions – must list the specific restrictions), or if you are not allowed to return to work due to the injury (missed days). You must provide the follow-up notes to the David Heath, the Workers' Compensation Coordinator, after every appointment.**

6. IF YOU MISS MORE THAN 3 DAYS OF WORK TIME DUE TO THIS INJURY, you may be eligible to be paid for Temporary Total Disability (TTD) benefits. Contact the WY Workers' Compensation Claims Analyst at 307-777-8758 for details. Benefited employees who miss work due to an injury may use sick leave, vacation, or compensatory time to supplement their TTD benefits.

SUPERVISORY RESPONSIBILITIES:

1. Make sure the employee seeks medical treatment if necessary. **Ask the employee to take the UW Work-Related Injury Follow-up Form with them so the health care provider can fill it out during their appointment.**

2. Make sure the injured employee completes the **Wyoming Employee Report of Injury** thoroughly (please be specific), with a description of the work they were performing at the time of the injury. Review and sign the form and make sure it is submitted to the Workers' Compensation Coordinator in Human Resources within 10 days of the injury.

3. **If the employee sought medical treatment, do not allow the injured employee to return to work without a medical release.** The employee must submit a written notice indicating when they may return to work and whether there are any work restrictions. Ask the employee to let you know if they will have any additional medical appointments related to this injury.

4. If the injured employee sought medical treatment, make sure the employee submits the **UW Work-Related Injury Report Follow-up Form** to the Workers' Compensation Coordinator right away. A written note from the health care provider concerning the employee's ability to return to work **must** be provided after every appointment. **If the employee brings the note to you, send it to the Workers' Compensation Coordinator right away (it may be scanned and emailed or faxed to 766-5636).** The Wyoming OSHA Recordkeeping regulations have strict deadlines for compliance, so updates must be provided in a timely manner.

5. If the employee is released to light (restricted) duty, contact the Stephanie Thomas at (307) 777-8758 to initiate a Return to Work (Light Duty) agreement form.

For further information please contact:

David Heath, Workers' Compensation Coordinator for UW Human Resources Department,
Room 343, Hill Hall, 307-766-5693, daheath@uwyo.edu.

UW WORK-RELATED INJURY FOLLOW-UP FORM

MUST BE COMPLETED BY HEALTH CARE PROVIDER

Return this completed form to David Heath in HR, Hill Hall Room 343 – FAX 307-766-5636

Name of Patient: _____

Date: _____

Note to Health Care Provider: This information is needed to provide the data required by the Bureau of Labor Statistics. Please complete this form and give it to your patient or fax it to UW Human Resources at (307) 766-5636.

1. May the patient return to work? Yes _____ No _____ (**If Yes**; Date of Return: _____)

2. If no, how many days will the patient need to be away from the workplace? _____

3. Will the patient have any work restrictions? Yes No
   If yes, what are the restrictions **(please be specific)**. _____

   _____

   If yes, how many days of work restrictions? _____

4. When is the estimated date of return to **full duty without restrictions**? _____

5. Did the patient receive any of the following **treatments**? Check all that apply.

   ____Prescription medicines?
   ____Treatment for second- or third-degree burns?
   ____Application of stitches?
   ____Positive x-ray diagnosis indicating fracture of bones or teeth?
   ____Contaminated sharps injury?
   ____Other: Explain: _____

6. Additional Comments:

If a follow up appointment is scheduled, when? _____

Name of Health Care Provider (Please Print): _____

Signature: _____

Name of Business: _____ (revised 8/2024)

Return completed form to David Heath: daheath@uwyo.edu or interoffice mail to HR Hill Hall room 343, or FAX 307-766-5636

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

Please use **BLACK** ink. Do not cross zeros or sevens

Claim Number: _____

EMPLOYER INFORMATION

BUSINESS NAME			WORK COMP EMPLOYER #
UNIVERSITY OF WYOMING			22259
ADDRESS			
1000 E. UNIVERSITY AVE. DEPT. 3422			
CITY	**STATE**	**ZIP**	**PHONE**
LARAMIE	WY	82071	(307) 766-5693
TAX ID TYPE (FEIN OR SSN)	**TAX ID NUMBER**		**NATURE OF BUSINESS (MANUFACTURING, ETC.)**
FEIN	83-6000331		HIGHER ED

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:**

INJRPT

Revised 11/11

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 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 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 SIGNATURE _____ DATE _____

Bob Link
PRINT EMPLOYER NAME

AVP, Human Resources
TITLE

WORK COMP EMPLOYER # 22259 BUSINESS NAME UNIVERSITY OF WYOMING PHONE #: 307-766-5636

Return completed form to David Heath: daheath@uwyo.edu or interoffice mail to HR Hill Hall room 343, or FAX 307-766-5636

or mail original to: UW Human Resources, ATTN: David Heath
1000 E. University Ave. Dept 3422
Laramie, WY 82071

DO NOT WRITE IN THIS AREA

INJRPT

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

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