



Matthew H. Mead
Governor

State of Wyoming
Department of Workforce Services
DIVISION OF WORKERS' COMPENSATION
1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
<http://www.wyomingworkforce.org>



John Cox
Director
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Deputy Director

Intent to Participate in the Wyoming Workers' Compensation Spine Protocol

By signing this form I acknowledge my intent to participate in the Spine Protocol sponsored by Wyoming Workers' Compensation. I further acknowledge that I understand the following:

- (1) My participation in this protocol is voluntary. I understand that I may withdraw at any time without harming my future medical care or losing any benefits to which I might be entitled.
- (2) I understand that Wyoming Workers' Compensation will make the determination whether I qualify for participation in this protocol.
- (3) I understand that my provider may decide at any time that I should no longer participate in the protocol. Reasons can include but are not limited to, failure to attend scheduled appointments, failure to follow prescribed medical treatment plan, seeking services from other providers. I acknowledge that I will forfeit the completion incentive of \$250.00
- (4) I understand that at any time during the six (6) week period, my provider may determine that I require a referral to another level of care, specifically a surgical consultation. I acknowledge that I will forfeit the completion incentive of \$250.00.
- (5) My provider has explained the intent of the protocol along with the potential risks and benefits. I understand my responsibility related to participation in the protocol.
- (6) I acknowledge that I will receive an incentive of \$250.00 at this time and will receive an additional \$250.00 at the completion of the six (6) week protocol or upon my return to work, whichever date comes first.

(Signature)

(Date)

(Provider Signature)

(Date)

Provider will submit this form with the initial visit medical report.

Please fax to 307-322-4763 or call 307-322-0291 for more information.

