WYOMING WORKERS' COMPENSATION DIVISION P.O. Box 20207, Cheyenne, WY 82003-7005 1-307-777-7441 Fax: 1-307-777-6552	Attn: **Claim Number:**

EMPLOYEE'S APPLICATION FOR TEMPORARY TOTAL DISABILITY BENEFITS

Please return the completed form to the address or fax shown above. An incomplete application may result in a denial of benefits.

Name (Print or Type)	Social Security Number	Date of Birth	Date of Injury
Address	**City, State, Zip**	**Phone Number**	**Email Address**

Per §27-14-404(d)(iii), you are ineligible for temporary total disability benefits if you are receiving unemployment benefits. Any attempt to obtain temporary total disability benefits while receiving unemployment compensation may result in criminal prosecution.

1. Are you receiving unemployment compensation? Yes / No Initials _____
2. Have you received unemployment compensation since the date of injury? Yes / No Initials _____
3. Are you required to make child support payments by court order? Yes / No Initials _____
4. Are you currently working or engaged in any activity which is normally performed for pay? Yes / No Initials _____

If you answered yes to question 4, provide the following: Dates of employment: From _____ To _____ PT / FT

Description of work performed:

By signing below, I hereby make application and claim for temporary total disability benefits. I understand the Division will rely on current medical opinion and current medical literature to determine my eligibility for these benefits.

I agree to notify the Division and my health care provider(s) immediately if I return to any work after applying for this benefit.

Under penalty of prosecution under §27-14-510(a) for misrepresentation or false statement, I swear that the information given by me herein is true and correct. I authorize the Division to obtain from any source and release to other agencies, insurers or employers, any medical, employment or payroll information needed to determine eligibility under the Workers' Compensation Act. A copy of this release has the effect of the original.

Employee Signature: **Date:**

HEALTH CARE PROVIDER'S CERTIFICATION OF TEMPORARY TOTAL DISABILITY

THIS CERTIFICATION FULFILLS THE REQUIREMENT UNDER WS §27-14-404 AND §27-14-501(b) FOR TTD BENEFITS. THE HEALTH CARE PROVIDER SHALL EXAMINE THE INJURED EMPLOYEE AND FILE THIS WRITTEN REPORT WITH THE WYOMING WORKERS' COMPENSATION DIVISION.

Health Care Provider Name: (Print or Type)	Address:	Phone:

Diagnosis:	Do you believe this condition is work related?
	Yes / No / Unable to Determine

Date of last exam by certifying health care provider:	Date of next appointment:	Is surgery anticipated?
		Yes / No Date:

Can the claimant return to modified or light duty work at this time?	Date employee will be able to return to full duty work:
Yes / No	

IMPORTANT: List current physical restrictions (please be specific)**:**

Has the patient's injury resulted in an ascertainable loss?	§27-14-102(a)(ii): "**Ascertainable loss**" means that point in time in which it is apparent that permanent physical impairment has resulted from a compensable injury, the extent of the physical impairment due to the injury can be determined and the physical impairment will not substantially improve or deteriorate because of the injury.
Yes / No	

BASED ON MY EXAMINATIONS, CONDUCT AND STATEMENTS OF THE EMPLOYEE, I HEREBY CERTIFY THAT I HAVE EXAMINED THE ABOVE PATIENT WITHIN THE LAST SIXTY (60) DAYS AND THAT THE ABOVE PATIENT IS TEMPORARILY DISABLED FROM RETURNING TO ANY GAINFUL EMPLOYMENT EXCEPT AS SET FORTH ABOVE. **THE EXPECTED DURATION OF TEMPORARY TOTAL DISABILITY IS:**

From: Through:

Signature of Health Care Provider: **Date:**

FOR OFFICE USE ONLY