



**Matthew H. Mead**  
Governor

# State of Wyoming

## Department of Workforce Services

DIVISION OF WORKERS' COMPENSATION

Risk Management

1510 East Pershing Boulevard, West Wing

Cheyenne, Wyoming 82002

307-777-8990

<http://www.wyomingworkforce.org>



**John Cox**  
Director  
**John Ysebaert**  
Deputy Director

Fiscal Year 2018

Dear Applicant,

Thank you for your interest in the Workplace Safety Contract Program. Applications will be reviewed on a quarterly basis. The review schedule is as follows:

- 1<sup>st</sup> Quarter applications will be reviewed the first week of April;
- 2<sup>nd</sup> Quarter applications will be reviewed the first week of July;
- 3<sup>rd</sup> Quarter applications will be reviewed the first week of October;
- 4<sup>th</sup> Quarter applications will be reviewed the first week of January.

Employers are eligible for up to \$10,000 per fiscal year; July 1 – June 30. If an application is approved, the contract must be signed prior to July 1 for the current funding cycle. Incomplete applications may be returned or denied. Please provide all requested documentation listed at the end of the application.

Employers must be current on payments to Workers' Compensation and/or Unemployment Insurance for the application to be considered.

Upon approval, the employer will be required to provide reporting as designated in the contract. If the employer chooses to not report, the funding shall be returned to Workers' Compensation.

The Workplace Safety Contracts program will cover equipment or training related to safety only. No health equipment will be considered; other than hearing conservation, respiratory programs, and eye protection which exceeds OSHA requirements.

Sincerely,

Risk Management  
[businessrisk@wyo.gov](mailto:businessrisk@wyo.gov)

## WORKPLACE SAFETY CONTRACT APPLICATION - Equipment

**Effective immediately, the program will not providing funding for the following:** building and/or property improvements, equipment intended to meet OSHA or MSHA compliance, office interventions, personal protective equipment (unless the employer can demonstrate the PPE exceeds the minimum requirements for OSHA), passive devices (i.e. cameras or security equipment), routine equipment replacements, equipment purchased prior to the contract, equipment that provides the employer with a competitive advantage, ergonomic equipment, earthmoving equipment, skid steers, scissor lifts, forklifts, powered hand tools, standard guard railing systems, and AED's.

*All disallowed equipment can be viewed in the WC Rules and Regulations, Chapter 11, Section 4(f).*

**Legal Business Name:** \_\_\_\_\_

**DBA or Doing Business As:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

**Mailing Address (if different than above):** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

<b>Primary Contact Information:</b>	<b>Signatory</b> (individual with legal authority to sign the contract)
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Job Title: _____	Job Title: _____
Phone Number: _____	Phone Number: _____
Email: _____	Email: _____

**Current Number of Employees:** \_\_\_\_\_

**Business Type:** \_\_\_\_\_

**Workers' Compensation Number:** \_\_\_\_\_

<b>For Office Use Only</b>	
Post Mark Date:	Total Equipment Cost:
Date Received:	Total Estimated Expenses:
Application Number:	Business Match:
Date Approved/Denied:	Potential Contract Amount:
Auto Approval Y / N	DWS Employee:

**EQUIPMENT INFORMATION** (Please complete for each unique piece of equipment)

**Equipment Name:** \_\_\_\_\_

**Equipment Model:** \_\_\_\_\_

**Equipment Description:** \_\_\_\_\_

**Equipment Manufacturer:** \_\_\_\_\_

**In what way would this equipment affect safety within your company? Please explain.** \_\_\_\_\_

**What equipment or process is currently in place to ensure employee safety?** \_\_\_\_\_

**How does the requested equipment exceed OSHA or MSHA requirements?** \_\_\_\_\_

**Is this an equipment replacement? Yes No** \_\_\_\_\_

**Number of employees equipment will affect in performance or job duties:** \_\_\_\_\_

**EQUIPMENT BUDGET**

<b>Equipment Count</b> (Number of pieces of equipment to be purchased)	
<b>Equipment Cost</b> (Per piece, Provide price quote)	
<b>Total Equipment Cost</b> (Equipment count x Equipment cost)	
<b>Business Match</b> (10% of total equipment cost)	
<b>Total Amount for Equipment</b> (Not to exceed \$10,000)	

**APPLICATION CHECKLIST**

**The following attachments are required unless otherwise noted:**

- Price quotes for equipment
- Equipment description(s) from manufacturer(s)

**SIGNATURE**

I hereby certify that the information on this application is true and accurate to the best of my knowledge. I am aware that any false information or intended omissions may subject me or my business to civil or criminal penalties for filing false public records and may result in forfeiture or repayment of any award approved through this program.

Authorized Signature (Signatory): \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Date: \_\_\_\_\_

**Please mail or deliver application to:**

Department of Workforce Services  
Workers' Compensation  
Risk Management  
1510 E. Pershing Blvd.  
Cheyenne, WY 82002

307-777-5961  
BusinessRisk@wyo.gov