



**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

[www.wyomingworkforce.org](http://www.wyomingworkforce.org)



**John Cox**  
Director

**John Ysebaert**  
Deputy Director

### Workplace Safety Contracts – Safety Improvement Fund Fiscal Year 2019

This program allows employers to apply for up to \$10,000 per fiscal year (July 1 – June 30). The funds must go towards equipment or training to improve safety within the company.

#### Eligibility Requirements

- The employer must be in good standing with Workers' Compensation and the Secretary of State's office
- All disallowed equipment can be found in the WC Rules & Regulations, Chapter 11, Section 4(f)

#### Items Needed to Complete the Application

- All pages must be filled out
- Product information on the equipment must be provided OR detailed course information for the training
- Price quotes must be included with the application

#### Application Instructions

- Complete the application and submit to the Risk Management team via mail or email
  - Once Risk Management has received your application, employers should submit Vendor Management forms to ensure a smooth payment process upon approval
- Applications are reviewed on a quarterly basis; deadlines can be found on the Risk Management website

#### Contract Process

- Upon approval, the Risk Management team will work with the Attorney General's office to draft the Safety Improvement Fund contract
- Risk Management will keep employers informed of the contract progress, but employers should be prepared to wait 3-5 weeks post-application approval to receive the contract for signature
- Once the contract is fully executed (signed by the Attorney General, signed by the employer and signed by the Department of Workforce services), payment will be issued as soon as possible

#### Reporting Requirements

- Invoices will be due ninety (90) days post contract execution
- Reporting on injury statistics will be due at three hundred and sixty-five (365) days post contract execution



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**Workplace Safety Contracts – Safety Improvement Fund**  
**Application for Training**

Legal Business Name:		
9-Digit Workers' Compensation Number:		
Street Address:		
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:

Primary Contact Information	Legal Signatory Contact Information
First Name:	First Name:
Last Name:	Last Name:
Job Title:	Job Title:
Phone Number:	Phone Number:
Email:	Email:

Industry:
Current number of employees:
Number of employees affected by equipment:

**Application Checklist**

The following items must be included with your application. Please check off each item to ensure your application is complete.

- Price quotes or price information for the training
- Proposed curriculum and registration material for the training (must have costs broken down)

**Training Information** – Please complete this form for each training or class

Training Start Date (including instructor travel; employee travel is not covered):
Training Completion Date (including instructor travel; employee travel is not covered):
Training Course Title & Description:
Will this training enhance safety culture or reduce injuries? If yes, please explain:
What current training or process is in place? Please explain.
In what way will the training positively affect safety within your company? Please explain.

**Training Budget**

<b>Allowable Expenses</b>	<b>Estimated Amount</b> (attach price quote)
Registration, Tuition or Class Fees	
Class Materials & Supplies	
Other Instructor Fees (hired instructors only)	
Air Fare (hired instructors only)	
Hotel (hired instructors only)	
Mileage (hired instructors only)	
<b>Total Estimated Expenses</b>	
<b>10% Employer Match</b>	
<b>Potential Contract Amount</b>	

## Application Signature

I hereby certify that the information provided in 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 company to civil or criminal penalties for filing false public records and my result in forfeiture or repayment of any award approved through this program.

Authorized Signature (legal signatory): \_\_\_\_\_

Printed Name: \_\_\_\_\_

Job Title: \_\_\_\_\_

Date: \_\_\_\_\_

**Please mail, email or deliver the application to:**

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

[BusinessRisk@wyo.gov](mailto:BusinessRisk@wyo.gov)

**For Office Use Only**

Date Received:	Total Training Cost:
Application Number:	Business Match:
Year/Quarter Reviewed:	Potential Contract Amount:
Approved/Denied:	Total Approved Amount: