

<b>WYOMING WORKERS' COMPENSATION DIVISION</b> <b>P.O. Box 20207, Cheyenne, WY 82003-7005</b> <b>1-307-777-7441 Fax: 1-307-777-6552</b>	Attn: _____ <b>Claim Number:</b> _____
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**EMPLOYEE'S APPLICATION FOR TEMPORARY TOTAL DISABILITY BENEFITS: EXTRAORDINARY CIRCUMSTANCES**  
 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.

**You have a choice of receiving benefit payments by direct deposit or prepaid debit card. Please contact your claims analyst for more information**

**Employee Signature:** \_\_\_\_\_

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

**HEALTH CARE PROVIDER'S CERTIFICATION OF TEMPORARY TOTAL DISABILITY: EXTRAORDINARY CIRCUMSTANCES**

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
Date of last exam by HCP	Date of next appointment	Diagnosis	Is surgery anticipated?	
			Yes / No Date: _____	
Do you believe this condition is work related?		Does claimant remain totally disabled due solely to the work-related injury?		
Yes / No		Yes / No		
Can claimant return to gainful employment at this time?		Do you expect claimant to return to gainful employment within the next twelve (12) months?		
Yes / No		Yes / No		
Can claimant return to modified or light duty work at this time?		Has claimant been compliant with the recommended treatment plan? If no, explain.		
Yes / No		Yes / No Explain: _____		

**IMPORTANT:** List current physical restrictions (be specific): \_\_\_\_\_

**Has the patient's injury resulted in an ascertainable loss?**

Yes / No

§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.

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 THERE IS CLEAR AND CONVINCING EVIDENCE THAT THE CLAIMANT REMAINS TOTALLY DISABLED, DUE SOLELY TO A WORK-RELATED INJURY; HAS NOT RECOVERED TO THE EXTENT THAT HE OR SHE CAN RETURN TO GAINFUL EMPLOYMENT; REASONABLY EXPECTS TO RETURN TO GAINFUL EMPLOYMENT WITHIN 12 MONTHS FOLLOWING THE DATE OF THE FIRST TTD CLAIM OCCURRING AFTER THE EXPIRATION OF THE 24-MONTH PERIOD; DOES NOT HAVE AN ASCERTAINABLE LOSS; HAS TAKEN ALL REASONABLE MEASURES TO FACILITATE RECOVERY, INCLUDING COMPLIANCE WITH THE RECOMMENDATIONS OF THE TREATING PHYSICIAN. **THE EXPECTED DURATION OF TEMPORARY TOTAL DISABILITY IS:**

From: \_\_\_\_\_ Through: \_\_\_\_\_

**Signature of Health Care Provider:** \_\_\_\_\_

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