DIVISION OF WORKERS COMPENSATION
KS DEPT OF HUMAN RESOURCES
800 SW JACKSON STE 600
TOPEKA KS 66612-1227

EMPLOYER'S REPORT OF ACCIDENT

Submit original report only

DO NOT WRITE IN THIS SPACE

OSHA Case or File Number ______

There is a $250 penalty for repeated failure to file Accident Reports within 28 days of the employer's receipt of knowledge of the accident.

READ INSTRUCTIONS BEFORE FILLING IT OUT.

1. Federal Employers Identification Number ______
2. Name of Employer ______ Telephone Number ______
3. Mailing Address ______ Street City State Zip Code
4. Location, if different from mailing address ______ Street City State Zip Code
5. Nature of Business ______ S.I.C. Code ______ Dept. or Division ______
6. Name of Employee ______ First Middle Last Age ______ Sex ______
7. Home Address ______ Street City State Zip Code
8. Soc. Sec. # ______ Birth Date ______ Employee's Occupation ______ Home Phone Number ______
9. Date of Injury or Occupational Disease ______ Time of Injury ______ A.M./P.M.
   Date Disability Began ______ Gross Average Weekly Wage ______
10. Place of Accident or last exposure ______ City County State
11. Was accident or last exposure on employer's premises? ☐ YES ☐ NO
12. How did accident occur? ______
13. What was employee doing when injured? ______
14. Name substance or object that directly caused injury ______
15. Describe in detail nature and extent of injury, indicate part of body involved ______
16. Was worker admitted to hospital? ☐ YES ☐ NO Date ______ Treated by emergency room only? ☐ YES ☐ NO
    Hospital name & address ______
17. Name and address of attending physician or clinic ______
18. Has employee returned to regular duty? ☐ YES ☒ NO Light duty? ☐ YES ☐ NO Date ______
19. Is compensation now being paid? ☐ YES ☐ NO Date first/initial payment ______
20. Weekly compensation rate ______ Is further medical aid needed? ☐ YES ☐ NO ☐ UNKNOWN
21. Did employee die? ☐ YES ☒ NO If so, give date of death ______ (File amended report within 28 days if death subsequently occurs.)
22. Name and address of dependents (death cases only) ______
23. Insurance Carrier and Third Party Administrator ______
    Address ______ Street City State ZIP Phone
    Policy Number ______ Name of Agent ______
    Claim Number ______ Name of Claim Representative ______
24. Date of Report ______ Completed by ______ Title ______

AGE

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Y N

CAUSE

NATURE

SEVERITY

0 - NO TIME LOST

1 - TIME LOST

2 - MEDICAL

3 - FATAL

SOURCE

MEMBER

DO NOT WRITE IN THIS SPACE

Questions or comments can be directed to the Kansas Division of Workers Compensation, Topeka, KS - Phone: 1-800-332-0353

K-WC 1101-A (Rev. 1-02)

- SUBMISSION DOES NOT CONSTITUTE ADMISSION OF LIABILITY -