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**

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.

**DO NOT WRITE IN THIS SPACE**

**READ INSTRUCTIONS BEFORE FILLING IT OUT.**

1. Federal Employers Identification Number _____
2. Name of Employer _____ Telephone # (___) _____
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 _____ Emp's Occupation _____ Home Ph. # (___) _____
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
OD
Y N
CAUSE
NATURE
SEVERITY
O – 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 -**