



DIVISION OF WORKERS COMPENSATION
 KS DEPT OF LABOR
 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 _____ **Date of Hire** _____

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 _____ Age ____ Sex ____
First Middle Last

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 _____
 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

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