KANSAS
DEPARTMENT OF LABOR

EMPLOYER'S REPORT OF ACCIDENT

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

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 ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1. Federal Employer's Identification Number _____ Date of Hire _____
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 _____ NAICS or 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 Reported to Employer _____ 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 _____

COUNTY
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. 2-06)

- SUBMISSION DOES NOT CONSTITUTE ADMISSION OF LIABILITY -

OSHA Case Information
(not to be filed with the Division of Workers Compensation)

25. **Case number from the Log** _____ *(Transfer the case number from the Log after you record the case.)*

26. **Date of injury or illness** _____

27. **Time employee began work** _____ ☐ A.M. ☐ P.M.

28. **Time of event** _____ ☐ A.M. ☐ P.M. Check if time cannot be determined ☐

29. **What was the employee doing just before the incident occurred?** Describe the activity, as well as the tools, equipment or material the employee was using. Be specific. *Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."*

30. **What happened?** Tell us how the injury occurred. *Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was spraying with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."*

31. **What was the injury or illness?** Tell us the part of the body that was affected and how it was affected. Be more specific than "hurt," "pain," or "sore." *Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."*

32. **What object or substance directly harmed the employee?** *Examples: "concrete floor"; "chlorine"; "radial arm saw."* If this question does not apply to the incident, leave blank.

33. **If the employee died, when did death occur?** Date of death _____

General Instructions

Please answer every question on the accident report. Failure to provide all answers may cause the accident report to be returned to the employer. Returned accident reports would most likely cause delays in benefits being paid to the injured employees and could subject the employer to fines.

Submit the original report only. Reports must be typewritten, computer generated, or neatly printed in black ink. Please avoid faxing or sending copies of accident reports, as they are difficult for the Division to microfilm.

The employer should send this accident report to its insurance carrier, third party administrator or pool association as indicated in the employer's insurance contract. The employer is responsible for submitting or causing the original report to be sent to the Division's office within 28 days of the date of the employer's receipt of knowledge of the accident.

Submission of this Employer's Report of Accident does not constitute a written claim.

Definition of an Incapacitating Injury

The Workers Compensation Act sets forth a strict time frame for filing of accident reports with the Division. The controlling statute is K.S.A. 44-557(a), which reads as follows:

> (a) it is hereby made the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

Accident reports are not required for every work related injury. The statute requires a report to be filed when the worker's whole or partial incapacity continues beyond the "day, turn, or shift which such injuries are sustained" as the result of accident. "Incapacity" is not specifically defined within the law, but the Division believes that the Legislature's intent was to reference a worker's whole or partial loss of the ability to perform his or her ordinary job tasks. When in doubt, keep in mind the law contains no penalty for filing a report that ultimately proves to be unnecessary. There are penalties, however, for failing to file a report when one was required. Those penalties are fines and limitations on the defenses the employer may assert should a claim be filed.

Instructions for Specific Items

Item 14: Name the object or substance which directly injured the employee. Examples: machine or object employee struck or struck employee; vapor or poison employee inhaled or swallowed; chemicals or radiation which irritated employee's skin; if hernia, the object employee was lifting or pulling; etc.

Item 15: Please be as specific as possible indicating all that is known about the injury. Name part of body injured.

KANSAS DEPARTMENT OF LABOR

Written Claim for Workers Compensation

In order to protect your rights for possible future workers compensation benefits, **a written claim must be filed with your employer** within 200 days after one of the following:

- The date of accident,
- The last compensation paid or
- The last approved medical treatment.

An accident report filed with the Division of Workers Compensation IS NOT a written claim.

To file a written claim with your employer:

In-person:
Complete the **bottom half** of this form and give to your employer. Have employer complete and sign the **top half** as acknowledgement of receipt of your written claim – keep for your records.

By mail:
Complete **bottom half** of form and mail to your employer by certified mail, return receipt requested.

Employee's Receipt

ATTENTION: This receipt is for employee's records. **Do not send to the Division of Workers Compensation**.

I hereby acknowledge receipt of written claim:

Employer's Signature_____ Date Received:_____

Employee's name:_____

Date of alleged accident:_____

(For Employee's Records)

(For Employer)

KANSAS
DEPARTMENT OF LABOR

Written Claim for Workers Compensation

Date: (month/day/year)_____

To (employer):_____

Street:_____ City:_____ State: _____ Zip:_____

You are herewith informed that I claim compensation in accordance with the Workers Compensation laws of Kansas by reason of an accident which arose out of and in the course of my employment with you on or about (date: month/day/year)_____

Signature (worker making claim):_____ Social Security No.:_____

Street:_____ City:_____ State: _____ Zip:_____

EMPLOYER INSTRUCTION: Please forward this claim to your workers compensation insurance carrier or to your self-insurance claim processing office.

Federal Privacy Act Disclosure Section 7(a)(2)(B)

The mandatory requirement that social security number be included in forms filed with the Division of Workers Compensation is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, since our regulations which require its disclosure were in existence before January 1, 1975. The number is used as a means of identifying all the various records in the Division of Workers Compensation pertaining to an individual.

The use of social security numbers is made necessary because of the large number of applicants who have similar names and birth dates, and whose identities can only be distinguished by the social security number.