

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 _____	COUNTY
2. Name of Employer _____ Telephone Number (____) _____	
3. Mailing Address _____ <small>Street City State Zip Code</small>	CAUSE
4. Location, if different from mailing address _____ <small>Street City State Zip Code</small>	
5. Nature of Business _____ NAICS or S.I.C. Code _____ Dept. or Division _____	NATURE
6. Name of Employee _____ Age ____ Sex ____ <small>First Middle Last</small>	
7. Home Address _____ <small>Street City State Zip Code</small>	SEVERITY
8. Soc. Sec. # _____ Birth Date _____ Emp's Occupation _____ Home Ph. # (____) _____	0 - NO TIME LOST
9. Date of Injury or Occupational Disease _____ Time of injury _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Date Reported to Employer _____ Date Disability Began _____ Gross Average Weekly Wage \$ _____	1 - TIME LOST
10. Place of Accident or last exposure _____ <small>City County State</small>	2 - MEDICAL
11. Was accident or last exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO	3 - FATAL
12. How did accident occur? Employee States _____	
13. What was employee doing when injured? Employee States _____	SOURCE
14. Name substance or object that directly caused injury Employee States _____	MEMBER
15. Describe in detail nature and extent of injury, indicate part of body involved Employee State _____	DO NOT WRITE IN THIS SPACE
16. Was worker admitted to hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____ Treated by emergency room only? <input type="checkbox"/> YES <input type="checkbox"/> NO Hospital name & address _____	
17. Name and address of attending physician or clinic _____	
18. Has employee returned to regular duty? <input type="checkbox"/> YES <input type="checkbox"/> NO Light duty? <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____	
19. Is compensation now being paid? <input type="checkbox"/> YES <input type="checkbox"/> NO Date first/initial payment _____	
20. Weekly compensation rate \$ _____ Is further medical aid needed? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
21. Did employee die? <input type="checkbox"/> YES <input type="checkbox"/> 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 <u>KASB Workers Compensation Fund, Inc.</u> Address <u>PO Box 4526</u> <u>Topeka</u> <u>KS</u> <u>66604-4024</u> <u>785-273-3600</u> <small>Street City State Zip Phone</small> Policy Number _____ Name of Agent _____ Claim Number _____ Name of Claim Representative _____	
24. Date of Report _____ Completed by _____ Title _____	

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

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.