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.

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 _____ Age _____ Sex _____
   First *Middle* *Last*
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 _____

   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 _____

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 -

DO NOT WRITE IN THIS SPACE

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

General Instructions

1. Please answer every question on the accident report. Incomplete and/or illegible accident reports will be returned for corrections. Returned accident reports may cause delays in benefits being paid to your injured employees.

2. **Submit the original report only**. Reports must be **typewritten, computer generated** (if an exact duplicate of K-WC 1101-A), or neatly **printed** in **black** ink. Please avoid submitting faxed or photostat copies of accident reports, they are difficult for the Division to microfilm.

3. It is the employer's responsibility to insure that an accident report is filed when necessary. This may be done by sending it directly to the Division within **28 days** of the date of **the employer's receipt of knowledge** of the accident. It is also permissible to send a report to your insurance carrier, third party administrator or pool association as long as the report is submitted to the Division within the required time limit. Whichever method is used, **please avoid filing duplicate reports of the same accident. Only accidents which cause an incapacitating injury to the employee are required to be reported to the Division.**

4. 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 necessary 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. Under that criterium, the decision of whether to file a report is relative to the particular job and demands a judgment regarding how, if at all, the accident limited the worker. 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. The Division will of course, accept those reports the employer wishes to file.

Instructions for Specific Items

Item 14: Name the object or substance which directly injured the employee. Example: machine or thing he/she struck or struck him/her; vapor or poison he/she inhaled or swallowed; chemicals or radiation which irritated his/her skin; if hernias, the thing he/she 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.