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 93-4303502
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 AmTrust
    Address 1207 Hall Johnson Rd. (Street) Colleyville (City) TX (State) 76034 (Zip) 817-328-1931 (Phone)
    Policy Number SWC1511180 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 -**