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

EMPLOYER'S REPORT OF ACCIDENT

DO NOT WRITE IN THIS SPACE

Submit original report only

OSHA CASE OR FILE NUMBER

There is a $250 penalty for 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 **48-6029925** Date of Hire
2. Name of Employer **Adjutant General's Department** Telephone Number **(785) 274-1393**
3. Mailing Address **2800 SW Topeka Blvd.** **Topeka** **KS** **66611**
   Street City State Zip Code
4. Location, if different from mailing address
   Street City State Zip Code
5. Nature of Business **State Government** S.I.C. Code **9199** 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 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 **State Self-Insurance Fund - Room 920 - Landon State Office Bldg.**
    Address **900 SW Jackson Street** **Topeka** **KS** **66612-1251** **(785) 296-2364**
    Street City State Zip Code Phone
    Policy Number Name of Agent
    Claim Number Name of Claim Representative
24. Date of Report *Supv Signature* 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

K-WC 1101-A (REV. 7-04) **(SUBMISSION DOES NOT CONSTITUTE ADMISSION OF LIABILITY)**