Injured Employee's Report of Injury

*A report of accidental injury was submitted by your employer. Payment of disability compensation and/or medical expenses will be considered **after** this completed form and other information are received.*

1. Full name of injured employee: _____
2. Employee's address: _____
3. Telephone: Home: (___) _____ Cell: ( ) _____ Work: (___) _____
4. Employer/Agency: _____
5. Job Title: _____ Employee ID # or SSN: _____
6. Date and time of accident: _____
7. Missed work from: _____ thru _____
8. Date returned to work: _____ If not, then expected return to work date: _____
9. Describe the accident: (**What happened, where, how, witnesses**):

   _____

   _____

   _____
10. What injuries were incurred? _____
11. Name/address of attending and/or subsequent physicians or hospitals:

    _____

    _____
12. Have you received workers compensation benefits before? If so, provide details such as employer, carrier, nature and dates of injuries.

    _____

    _____

To claim compensation in accordance with Workers Compensation, sign and return this form to:

State Self-Insurance Fund
Room 900-N, Landon State Office Building
900 SW Jackson
Topeka, Kansas 66612

Phone: (785) 296-2364 **Fax:** (785) 296-6995

AUTHORIZATION

I hereby authorize and request any physician or hospital to permit a representative of the State Self-Insurance Fund to be furnished a copy of all medical records in connection with any past or present medical treatment associated with this injury. I am willing that a photocopy or fax of this authorization be accepted with the same authority as the original.

Signed: _____ Date: _____