



# 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 \_\_\_\_\_ 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 \_\_\_\_\_  
 Address \_\_\_\_\_  
Street City State ZIP Phone  
 Policy Number \_\_\_\_\_ Name of Agent \_\_\_\_\_  
 Claim Number \_\_\_\_\_ Name of Claim Representative \_\_\_\_\_

24. Date of Report \_\_\_\_\_ Completed by \_\_\_\_\_ Title \_\_\_\_\_

DO NOT WRITE  
IN THIS SPACE

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