KU HUMAN RESOURCES
The University of Kansas
1246 W. Campus Rd, Room 103
Lawrence, KS 66045-7521
Phone (785) 864-4946 Fax (785) 864-5790
humanresources.ku.edu

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 ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1. Federal Employer's Identification Number 48-6029925 Date of Hire _____
2. Name of Employer University of Kansas Telephone Number (785) 864-4946
3. Mailing Address Carruth-O'Leary, Room 103, 1246 W Campus Road (Street) Lawrence (City) (State) 66045-7521 (Zip Code)
4. Location, if different from mailing address _____ (Street) (City) (State) (Zip Code)
5. Nature of Business _____ NAICS or 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. # XXX-XX-XXXX Birth Date _____ Emp's Occupation _____ Home Ph. # _____
9. Date of Injury or Occupational Disease _____ Time of injury _____ ☐ A.M. ☐ P.M.
   Date Reported to Employer _____ 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
    Address 900 S. W. Jackson Street (Street) Topeka (City) KS (State) 66612 (Zip) (785) 296-2364 (Phone)
    Policy Number _____ Name of Agent _____
    Claim Number _____ Name of Claim Representative _____
24. Date of Report _____ Completed by _____ Title _____

COUNTY
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. 2-06) **- SUBMISSION DOES NOT CONSTITUTE ADMISSION OF LIABILITY -**

25. Employee's Work Phone Number _____

26. Supervisor's Name _____

27. Supervisor's Work Phone Number _____

28. Please list any witnesses to the incident with primary contact information:

_____

_____

29. Please list any short and long term prevention strategies to prevent future occurrences:

_____

_____

Once completed, please click the submit button to the right.

Submit

1. Once the form is completed, please click the submit button.
2. The "Default email application" box will open, click continue.
3. A new email box will open, click send.
4. Questions please contact: hrdept@ku.edu or 864-4946

General Instructions

A. All accidents that result in injury (medical expenses) or time loss (unable to report for duty at the beginning of the next scheduled work shift) must be reported to Human Resources within 48 hours of the accident.

B. Answer every question thoroughly on the accident form (http://www.humanresources.ku.edu/files/documents/1101a.pdf). Save the accident form and email it to HR (hrdept@ku.edu). **Retain a copy for departmental records and give one copy to the employee**.

C. The departmental Personnel Related Staff (PRS) completing the accident form should also complete the First Fill Letter (http://www.humanresources.ku.edu/files/documents/injured_workers_first_fill.pdf) to give to the injured employee in the event the doctor prescribes a drug(s) to treat the work-related injury.

D. All medical treatment for on-the-job injuries for Lawrence Campus employees is conducted at Lawrence Memorial Hospital, Business Health Center. Other employees of the University with off site locations, i.e., Parsons and Edwards Campuses, should report to the nearest emergency facility for treatment.

E. All medical bills should be submitted directly to:

CompAlliance SSIF
P.O. Box 1697
Topeka, KS 66601-1697

PLEASE DO NOT SEND ANY MEDICAL BILLS TO KU HUMAN RESOURCES. This will only delay processing of the bills.

F. Contacts for filling out form: HR Administrative Section at 4-4946 or hrdept@ku.edu.