Employer's Report of Accident KWC 1101-A (Rev 10-13)

Kansas State University
Division of Human Resources | 103 Edwards Hall | Manhattan, KS 66506-4801
(785) 532-6277 | fax: (785) 532-7693 | Email: benefits@ksu.edu

RESET

To request a medical appointment for non-life threatening injuries call the State Self Insurance Fund Office at 785-296-2364.

Read instructions page 2 | Type or Print | Fax to 785-532-7693 or | Email to benefits@ksu.edu within 3 days of accident

OSHA Case or File Number _____ (HR use only)

1. Federal Employer's Identification Number 486029925 Date of hire _____

2. Name of employer Kansas State University Phone (785) 532-6277

3. Mailing address 103 Edwards Hall (Street) Manhattan (City) KS (State) 66506 (ZIP)

4. Location, if different from mailing address _____ NA (Street) (City) (State) (ZIP)

5. Nature of business Higher Education NAICS or S.I.C. Code 9199 Dept. or division _____

6. Name of employee _____ (First) (Middle) (Last) Age _____ Sex _____

7. Home address _____ (Street) (City) (State) (ZIP)

K-State Email: _____ Phone # _____ Employee ID _____

8. SSN _____ Birth date _____ Employee's occupation _____ Home phone ( ) _____

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 and where 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 and 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 YES, give date of death _____ (File amended report within 28 days if death subsequently occurs.)

22. Supervisor and Personnel Specialist/Dept. Contact Names and daytime phone numbers _____

23. Insurance carrier and third party administrator *State Self Insurance Fund* _____
Address *900 SW Jackson Street, Room 900-N, Topeka, Kansas 66612* (Street) (City) (State) (ZIP) Phone (785) 296-2364
Policy number NA Name of agent NA
Claim number _____ Name of claim representative _____

24. Date of report _____ Completed by Stacy Divine 785-532-1873 Title Human Resource Professional III

FOR OFFICE USE

COUNTY

CAUSE

NATURE

SEVERITY

0 - NO TIME LOST
1 - TIME LOST
2 - MEDICAL
3 - FATAL

SOURCE

MEMBER

25. Employee's Signature_____ _____ Date _____ Employee's daytime phone # _____
By signing this, you have confirmed that all of the steps in the General Instructions have been completed.

26. Supervisor Signature_____ Date _____ Supervisor's daytime phone # _____
By signing this, you have confirmed that all of the steps in the General Instructions have been completed.

27. Department Head/Administrators Signature _____ Date _____

27. Additional Information_____

_____

_____

*Instructions for Questions 14 and 15
14. Name the object or substance that directly injured the employee. Example: machine or object employee struck or struck employee; vapor or poison employee inhaled or swallowed; chemicals or radiation which irritated employee's skin; if hernia, the object employee was lifting or pulling, etc.
15. Be as specific as possible indicating all that is known about the injury. Name the part of the body injured.

GENERAL INSTRUCTIONS

All accidents that result in injury, whether or not medical treatment is sought, must be **reported on this form to Human Resources within 3 days of the accident.**

MEDICAL TREATMENT **Non-life-threatening medical care**, call the State Self Insurance Fund Office (Workers' Compensation) at 785-296-2364. Medical treatment for most non-life threatening on-the-job injuries in Manhattan is provided by Mercy Regional Occupational Health Services (Mercy West). Employees of the University at other than Manhattan locations should report to the nearest medical facility for treatment after receiving authorization for treatment as noted above. **Life-threatening emergency**, go directly to the emergency room of any hospital.

MEDICAL BILLS Please do not send any medical bills to Human Resources**.** This will delay processing. All medical bills should be submitted by employees or departments directly to:

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

FORM COMPLETION

Please print or type. Answer every question thoroughly on the accident form. Failure to answer all questions may cause the report to be returned to the employer. Returned accident reports may cause a delay of benefits to the injured employees. The departmental Personnel Specialist/Supervisor completing the accident form should provide the employee the links below or with printed copies of the documents.

- State Self Insurance Fund Website for Workers' Compensation See FAQs and other information. http://www.kdheks.gov/hcf/ssif/
- Injured Worker's First Fill Prescription Form
- Information For Injured Employees

SEND THE 1101-A ACCIDENT FORM TO HUMAN RESOURCES WITHIN 3 DAYS OF THE ACCIDENT.

1. Download and complete this form. Please print or type.
2. Print and/or save copies for your file. Provide a copy to the employee.
3. Submit the completed form with signatures to HR via fax (785-532-7693) or email (preferred) to benefits@ksu.edu with the subject Accident Report – (Employees name and ID)
4. Contact for questions on filling out the form: benefits@ksu.edu, 785-532-6277

Definition of an Incapacitating Injury – K.S.A. 44-557

The Workers' Compensation Act sets forth a strict time frame for filing accident reports with the division. The controlling statute is K.S.A. 44-557(a), which reads as follows: (a) it is hereby made the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained. ***There are penalties for failing to file an accident report when one was required.*** *The penalties include fines and limitations on the defenses the employer/employee may assert if a claim is filed. There is a $250 penalty for repeated failure to file accident reports within 28 days of the date the employer is informed of the accident. Submission does not constitute admission of liability. Questions on this section or other processes/concerns, contact the Ombudsperson at the Department of Labor at 800-332-0353.*