KANSAS ACCIDENT REPORT

(To be filled out by Employer)

Company Name: _____

Reported by: _____ Phone Number: _____

Email: _____

Date of Injury: _____ Date Reported to Company: _____

Employee Information

Name: First _____ Middle _____ Last _____

Address: Line 1 _____

Line 2 _____

City _____ State ____ Zip _____

Phone: _____ Cell: _____ Note: _____

SSN: _____ ☐ Male ☐ Female DOB: _____

Occupation: _____ Hourly ROP: _____ OR Weekly ROP: _____

Class Code: _____ Is Individual? ☐ Employee ☐ Sub-Contractor ☐ Independent contractor

Employment Status: ☐ Full Time ☐ Part Time ☐ Terminated Date: _____

Language: ☐ English ☐ Spanish Hire State: ____ Hire Date: _____

Injury Information

Date of Injury: _____ Time: _____ ☐ AM ☐ PM

Place of Accident/Last Exposure Where? ☐ Co. Premises ☐ Vehicle ☐ Jobsite

Address: _____

City: _____ State: ____ Zip: _____

Was Employee injured out of state: ☐ Yes or ☐ No

If Yes, did employee sign Election of Jurisdiction Form: ☐ Yes ☐ No

Describe Accident:

_____

_____

_____

_____

Witnesses Names: _____

Result of Injury Information

☐ Admitted To Hospital ☐ Emergency Room Only ☐ Clinic Date: _____

Hospital/Clinic: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Has employee returned to duty? ☐ Full Duty ☐ Light ☐ No Date: _____

Is further medical aid needed? ☐ Yes ☐ No ☐ Unknown

☐ Needs Authorization for: _____

Name/or Facility: _____ Phone: _____

Notes:

_____

_____

_____

_____

Company Information

Does your company have a drug policy? ☐ Yes ☐ No

Was employee post accident drug tested? ☐ Yes ☐ No