KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

ACCIDENT REPORT

K-WC 1101-A (Rev. 1-12)

– SEE INSTRUCTIONS ON PAGE 2 –

Mail or fax ORIGINAL report to:
Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105
Fax: (785) 296-4216

Direct questions or comments to:
Toll-free (800) 332-0353

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.**

OSHA Case or File Number _____

1. Federal Employer's Identification Number_____ Date of hire _____
2. Name of employer_____ Phone _____
3. Mailing address_____
   Street *City* *State* *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 _____ Age_____ Sex_____
   First *Middle* *Last*
7. Home address _____
   Street *City* *State* *ZIP Code*
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? _____
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. Name(s) and address(es) of dependents (death cases only) _____
23. Insurance carrier and third party administrator MIDWEST FAMILY GROUP
    Address PO BOX 3930 URBANDALE IA 50323 Phone 800-225-5636
    Street *City* *State* *ZIP Code*
    Policy number_____ Name of agent_____
    Claim number_____ Name of claim representative_____
24. Date of report_____ Completed by_____ Title_____

FOR OFFICE USE

COUNTY

CAUSE

NATURE

SEVERITY

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

SOURCE

MEMBER

Instructions

You must answer every question; 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 and could subject the employer to fines.

Mail or fax the **original** report only. If not completed using the fillable PDF form, the report must be printed neatly in black ink or typewritten. If not legible, the report will be returned which will delay timely processing.

The employer must send this accident report to its insurance carrier, third party administrator or pool association as indicated in the employer's insurance contract. **The employer is responsible for submitting the original report to the Division of Workers Compensation within 28 days of the date the employer is informed of the accident.**

*Instructions for Questions 14 and 15

14: Name the object or substance which 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 body injured.

Definition of an Incapacitating Injury

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.

Accident reports are not required for every work-related injury. The statute requires a report to be filed when the worker's whole or partial incapacity continues beyond the "day, turn, or shift which such injuries are sustained" as the result of accident. "Incapacity" is not specifically defined within the law, but the division believes that the Legislature's intent was to reference a worker's whole or partial loss of the ability to perform his or her ordinary job tasks. When in doubt, keep in mind the law contains no penalty for filing a report that ultimately proves to be unnecessary. **There are penalties, however, for failing to file a report when one was required.** The penalties include fines and limitations on the defenses the employer may assert if a claim is filed.

OSHA Recordkeeping

The employer must complete an Injury and Illness Incident Report, OSHA Form 301, within seven (7) days of learning that a work-related injury or illness has occurred. According to OSHA's recordkeeping rule, you must keep Form 301, or an equivalent substitute on file for five (5) years.

To learn more about OSHA's recordkeeping requirements and download forms, visit:
www.osha.gov/recordkeeping/RKforms.html