KS Accident Report

Company Name: _____

Reported by: _____ Phone Number: _____

Assigned Adjuster: _____ E-Mail: _____

Date of Injury: _____

Reported to Fund Date: _____ Reported to Company Date: _____

Employee Information

Name: First _____ Middle _____ Last _____

Address: Line 1 _____

Line 2 _____

City _____ State _____ Zip _____

Phone: _____ Cell: _____ Note: _____

SSN: _____ ☐ Male ☐ Female DOB: _____

Occupation: _____ Hourly ROP: _____ Weekly ROP: _____

Class Code: _____ Is Individual? ☐ EE ☐ 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: _____ ST: _____ Zip: _____

Jurisdiction State: _____

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: _____ ST: _____ 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