Kansas

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 48-0980676 Date of hire *
2. Name of employer Kansasland Tire Phone _____
3. Mailing address * 2904 S Spruce (Street) Wichita (City) KS (State) 67216 (ZIP Code)
4. Location, if different from mailing address _____ (Street) _____ (City) _____ (State) _____ (ZIP Code)
5. Nature of business tires and Service NAICS or S.I.C. Code 441320 Dept. or division *
6. Name of employee _____ (First) _____ (Middle) _____ (Last) Age _____ Sex _____
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 ☐ Federated Mutual Insurance Company ☒ Federated Service Insurance Company
    Address P.O. Box 419444 (Street) Kansas City (City) MO (State) 64141-6444 (ZIP Code) Phone (800) 445-0109
    Fax 866-636-8660
    Policy number 339-495-4 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