

# ACCIDENT REPORT

K-WC 1101-A (Rev. 10-13)

**- SEE INSTRUCTIONS ON PAGE 2 -**

Send this completed form to your insurer, third party administrator or pool association for submission electronically to the Division of Workers Compensation.  
**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*
4. Location, if different from mailing address \_\_\_\_\_  
*Street City State ZIP*
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*
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 \_\_\_\_\_  
Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
*Street City State ZIP*  
Policy number \_\_\_\_\_ Name of agent \_\_\_\_\_  
Claim number \_\_\_\_\_ Name of claim representative \_\_\_\_\_
24. Date of report \_\_\_\_\_ Completed by \_\_\_\_\_ Title \_\_\_\_\_

<b>FOR OFFICE USE</b>
COUNTY
CAUSE
NATURE
SEVERITY
0 - NO TIME LOST 1 - TIME LOST 2 - MEDICAL 3 - FATAL
SOURCE
MEMBER

**Accident Report**

K-WC 1101-A (Rev. 10-13)

## 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.

The employer must send this accident report to its insurance carrier, third party administrator or pool association for electronic submission to the Kansas Department of Labor Division of Workers Compensation.

### \*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](http://www.osha.gov/recordkeeping/RKforms.html)