

EMPLOYER'S REPORT OF ACCIDENT

Submit Original Report only

OSHA Case or File Number _____

There is a \$250 penalty for repeated failure to file Accident Reports within 28 days of the employer's receipt of knowledge of the accident.

DO NOT WRITE IN THIS SPACE

READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM.

1. Federal Employer's Identification Number _____ Date of Hire _____	COUNTY
2. Name of Employer _____ Telephone Number _____	
3. Mailing Address _____ <small>Street City State Zip Code</small>	CAUSE
4. Location, if different from mailing address _____ <small>Street City State Zip Code</small>	
5. Nature of Business _____ NAICS or S.I.C. Code _____ Dept. or Division _____	NATURE
6. Name of Employee _____ Age ____ Sex _____ <small>First Middle Last</small>	
7. Home Address _____ <small>Street City State Zip Code</small>	SEVERITY
8. Soc. Sec. # _____ Birth Date _____ Emp's Occupation _____ Home Ph. # _____	
9. Date of Injury or Occupational Disease _____ Time of injury _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Date Reported to Employer _____ Date Disability Began _____ Gross Average Weekly Wage \$ _____	0 - NO TIME LOST 1 - TIME LOST 2 - MEDICAL 3 - FATAL
10. Place of Accident or last exposure _____ <small>City County State</small>	
11. Was accident or last exposure on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO	
12. How did accident occur? _____	
13. What was employee doing when injured? _____	SOURCE
14. Name substance or object that directly caused injury _____	MEMBER
15. Describe in detail nature and extent of injury, indicate part of body involved _____	DO NOT WRITE IN THIS SPACE
16. Was worker admitted to hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____ Treated by emergency room only? <input type="checkbox"/> YES <input type="checkbox"/> NO Hospital name & address _____	
17. Name and address of attending physician or clinic _____	
18. Has employee returned to regular duty? <input type="checkbox"/> YES <input type="checkbox"/> NO Light duty? <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____	
19. Is compensation now being paid? <input type="checkbox"/> YES <input type="checkbox"/> NO Date first/initial payment _____	
20. Weekly compensation rate \$ _____ Is further medical aid needed? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
21. Did employee die? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, give date of death _____ (File amended report within 28 days if death subsequently occurs.)	
22. Name and address of dependents (death cases only) _____	
23. Insurance Carrier and Third Party Administrator _____ Address _____ <small>Street City State Zip Phone</small> Policy Number _____ Name of Agent _____ Claim Number _____ Name of Claim Representative _____	
24. Date of Report _____ Completed by _____ Title _____	

Questions or comments can be directed to the Kansas Division of Workers Compensation, Topeka, KS Phone: 1 800 332 0353

25. Employee's Work Phone Number _____

26. Supervisor's Name _____

27. Supervisor's Work Phone Number _____

General Instructions

- A. All accidents that result in injury (medical expenses) or time loss (unable to report for duty at the beginning of the next scheduled work shift) must be reported to Human Resources within 48 hours of the accident.
- B. Answer every question thoroughly on the accident form (<http://www.humanresources.ku.edu/files/documents/1101a.pdf>). Save the accident form and email it to HR (hrdept@ku.edu). **Retain a copy for departmental records and give one copy to the employee.**
- C. The departmental Personnel Related Staff (PRS) completing the accident form should also complete the First Fill Letter (http://www.humanresources.ku.edu/files/documents/injured_workers_first_fill.pdf) to give to the injured employee in the event the doctor prescribes a drug(s) to treat the work-related injury.
- D. All medical treatment for on-the-job injuries for Lawrence Campus employees is conducted at Lawrence Memorial Hospital, Business Health Center. Other employees of the University with off site locations, i.e., Parsons and Edwards Campuses, should report to the nearest emergency facility for treatment.
- E. All medical bills should be submitted directly to:

CompAlliance SSIF
P.O. Box 1697
Topeka, KS 66601-1697

PLEASE DO NOT SEND ANY MEDICAL BILLS TO KU HUMAN RESOURCES. This will only delay processing of the bills.
- F. The accident report form should be completed by the supervisor or departmental PRS member and dated. In some cases, the employee or supervisor may first complete an incident report if no medical expenses have been incurred and medical treatment has not been sought yet. An 1101-A form must then be completed if the accident will result in medical expense or time loss.
- G. Contacts for filling out form: HR Administrative Section at 4-4946 or hrdept@ku.edu.

How to send the 1101-A Accident Form to Human Resources

1. Download or complete the accident form from the HR website at www.humanresources.ku.edu/files/documents/1101a.pdf.
2. Fill out the form and save it on a secured drive. You will need to print one or two copies of the completed form: One for your file (or you may keep the saved copy on a secured drive) and provide a copy to the employee.
3. To submit the form to HR, email it to hrdept@ku.edu and place in the email subject line the employee's name.
4. Contact for accessing and printing form: hrdept@ku.edu or 864-4946.

Department of Human Resources

1246 W. Campus Rd, Room 103 | Lawrence, KS 66045-7521 | (785) 864-4946 | Fax (785) 864-5790

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