Injured Employee's Report of Injury

*A report of accidental injury was submitted by your employer. Payment of disability compensation and/or medical expenses will be considered **after** this completed form and other information are received.*

1. Full name of injured employee:_____

2. Employee's address:_____

3. Telephone: Home: (____) _____; Work: (____) _____

4. Employer/Agency:
_____

5. Job Title:_____ Employee ID # or SSN:_____

6. Date and time of accident: _____

7. Missed work from: _____ thru: _____

8. Date returned to work: _____ If not, then expected return to work date:_____

9. Describe the accident: (**What happened, where, how, witnesses**):
_____
_____
_____

10. What injuries were incurred?
_____
_____
_____

11. Name/address of attending and/or subsequent physicians or hospitals:
_____
_____

12. Have you received workers compensation benefits before? If so, provide details such as employer, carrier, nature and dates of injuries.
_____
_____
_____

To claim compensation in accordance with Workers Compensation, sign and return this form to:

State Self-Insurance Fund
Mills Building, Suite 600
109 SW 9th Street
Topeka, Kansas 66612-1251
Phone: (785) 296-2364 Fax: (785) 296-6995

AUTHORIZATION

I hereby authorize and request any health care provider to provide a copy of all medical records related to me, to a representative of the State Self Insurance Fund and any other Agent acting on their behalf. This includes medical records from any requested time period and services for any medical condition. At times it is necessary to obtain records prior to and after the date of injury in order to assess compensability and related issues. I understand that a photocopy or fax of this authorization can be accepted with the same authority as the original. I understand that the Kansas workers compensation program is exempt from Health Insurance Portability and Accountability Act (HIPAA) and that any requirements for authorization under that are inapplicable.

Signed: _____ Date: _____