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 Policy #100041335

1. Federal Employer's Identification Number ______ Date of hire ______
2. Name of employer Sumner County Educational Svcs. Phone 620-326-8935
3. Mailing address 2612 N. A St. (Street) Wellington (City) Ks (State) 67152 (ZIP Code)
4. Location, if different from mailing address ______ Street ______ City ______ State ______ ZIP Code
5. Nature of business Education NAICS or S.I.C. Code ______ 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 ______
    Address ______ Street ______ City ______ State ______ ZIP Code ______ Phone ______
    Policy number ______ 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