DIVISION OF HUMAN RESOURCES USE ONLY
CASE #_____
1101A SENT_____
BROCHURE SENT_____
DATE REPORTED_____ph/fax/vm/e
REPORTED BY_____
DEPARTMENT_____
PHONE NUMBER_____

KANSAS STATE UNIVERSITY
Division of Human Resources
103 Edwards Hall
Manhattan, KS 66506-4801

RESET

PER-17
(02/2007)

ACCIDENT/INJURY REPORT
ADDENDUM TO THE 1101A FORM (Workers' Compensation)
SUBMIT IN DUPLICATE

All injuries/accidents that occur on Kansas State University property and/or in the line of duty **must be telephoned to the Division of Human Resources**, 532-1873 or 6277, upon occurrence. This Accident/Injury Report is to be submitted to the Division of Human Resources within **three working days**.

ANSWER ALL QUESTIONS

Name_____
First MI Last Age Sex

Status: Faculty (☐) Staff (☐) Student Employee (☐) Student (☐) Visitor (☐)

Job Title_____ Department_____

Home/Local Address_____
Street City State Zip Code

Employee ID Number_____ Date of Birth_____

Hourly or Bi-Weekly Rate $_____ Work Phone_____ Home/Local Phone_____

Date of Injury, Occupational Disease or Disability_____ Time of Injury_____ (a.m./p.m.)

Was accident/injury work related? Yes (☐) No (☐) Reoccurrence? Yes (☐) No (☐)

Location of accident/injury_____
City County State

If on KSU property, name of building/location_____

Name of witness(es) to accident_____

Name of supervisor and department telephone number_____

Completely describe how accident/injury occurred (BE SPECIFIC). Example: Right foot slipped on ice on north steps of Anderson Hall._____

_____

_____

Describe injury (Name of body part, symptoms, and nature/extent of injury.) Example: left foot sprained and bruised._____

_____

_____

Was the injured employee treated by a physician? Yes (☐) No (☐)

If Yes, date of initial treatment_____

a. Name and address of physician_____

_____

b. Name and address of treating facility (e.g.) emergency room, hospital, clinic, etc.)_____

_____

Did the employee leave work for longer than the initial medical treatment? Yes (☐) No (☐)

If so, give the date returned to work_____ total number of work days missed_____
(not including date of injury/accident)

Were restrictions assigned by the treating physician making job accommodations necessary? Yes (☐) No (☐)

Did the employee die as a result of the accident/injury? Yes (☐) No (☐) If Yes, give date of death_____

If medical treatment is not required at the time of accident/injury but is later needed, contact the Division of Human Resources <u>immediately</u> once medical treatment is received.

Will follow-up medical treatment be needed? Yes (☐) No (☐)

_____ _____

Date Signature of injured person **(if available)**

<u>TO BE COMPLETED BY DEPARTMENT HEAD DIRECTOR</u>

_____ _____

Date Signature of Department Head/Director