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 has been 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 file a claim in accordance with Workers Compensation, complete and sign this form then return to:

State Self-Insurance Fund
Room 901-N, Landon State Office Building
900 SW Jackson
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 to a representative of the State Self-Insurance Fund and any other Agent acting on their behalf. I understand that a photocopy or fax of this authorization can be accepted with the same authority as the original. I understand that workers compensation is exempt from the Health Insurance Portability and Accountability Act (HIPPA) and that any requirements for authorization under that act are inapplicable.

Signed: ___________________________       Date: ___________________________

Form WC-9
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