

## 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: \_\_\_\_\_