

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

PER-17
(07/2009)

**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 immediately once medical treatment is received.

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

Date of Signature

Signature of injured person (if available)

Required: _____
Date supervisor or other department personnel were notified of accident/injury

TO BE COMPLETED BY DEPARTMENT HEAD DIRECTOR

Date

Signature of Department Head/Director