

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 are 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 claim compensation in accordance with Workers Compensation, sign and return this form to:

State Self-Insurance Fund
Room 900-N, Landon State Office Building
900 SW Jackson
Topeka, Kansas 66612

Phone: (785) 296-2364 **Fax:** (785) 296-6995

AUTHORIZATION

I hereby authorize and request any physician or hospital to permit a representative of the State Self-Insurance Fund to be furnished a copy of all medical records in connection with any past or present medical treatment associated with this injury. I am willing that a photocopy or fax of this authorization be accepted with the same authority as the original.

Signed: _____ Date: _____