

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  
(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 immediately once medical treatment is received.***

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of injured person (if available)

**TO BE COMPLETED BY DEPARTMENT HEAD DIRECTOR**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Department Head/Director