Accident Report by Injured Employee

This report must be **filled out completely** by the injured employee and sent to the Workers Comp Department **prior** to seeking treatment. Treatment sought outside the Workers Comp Department will be unauthorized.

Date Report Completed: _____

Full Name: _____

Home Address: _____

Cell Phone Number: _____ Occupation: _____

Date of Birth: _____

Social Security Number or Employee ID: _____

Date of Accident: _____ Time of Accident: _____

Building: _____ Location in Building: _____

Describe event and activity during accident: _____

_____

_____

What body parts were injured: _____

Type of injury: _____

Was protective equipment used: _____ Describe: _____

Witnesses Names: _____

Did you report this accident to your supervisor: _____ If not, why? _____

_____

Did you go to the hospital or clinic: _____ Name of hospital/ clinic: _____

Additional comments: _____

_____

Note: Your claim will be investigated for compensability and may be investigated for Workers Compensation fraud under (K.S.A) 44-5, 120. Workers Compensation fraud includes falsifying or exaggerating injuries, making a claim for injuries that occurred outside of work, working while collecting benefits, and making a claim for pre– existing injuries. These types of claims are punishable by Kansas Law.

Signature: _____ Date: _____

Email to rmbergsma@olatheschools.org once completed. Call (913)780-8051 if you would like to seek treatment.

Eyewitness Statement

This report must be completed by the eyewitness. Read questions carefully and make your answers complete and accurate.

Date Report Completed: _____

Full Name: _____

Home address: _____

Cell Phone: _____

Date of Accident: _____ Time of Accident: _____

Name of Person Injured: _____

In your own words, describe what happened: _____

_____

_____

_____

Additional comments: _____

_____

_____

Signature: _____ Date: _____

Email to rmbergsma@olatheschools.org once completed.