KWORCC Accident Report

Please complete and fax to 844-702-2354 or email to Wichita.FNOL@tristargroup.net

OSHA Case or File Number ____________

1. Federal Employer's Identification Number ____________ Date of hire ____________
2. Name of employer ____________ Phone ( ) ____________
3. Mailing address ____________
   Street City State ZIP
4. Location, if different from mailing address ____________
   Street City State ZIP
5. Nature of business ____________ NAICS or S.I.C. Code ____________ Dept. or division ____________
6. Name of employee ____________ Age ____ Sex ____
   First Middle Last
7. Home address ____________
   Street City State ZIP
8. SSN ____________ Birth date ____________ Employee's occupation ____________ Home phone ( ) ____________
9. Date of injury or occupational disease ____________ Time of injury ________ a.m. / p.m.
   Date reported to employer ____________ Date disability began ____________ Gross average weekly wage $____________
10. Place of accident or last exposure ____________
    City County State
11. Was accident or last exposure on employer's premises? ☐ YES ☐ NO
12. How did accident occur? ____________
13. What was employee doing when injured? ____________
14. Name substance or object that directly caused injury* ____________
15. Describe in detail nature and extent of injury, indicate part of body involved* ____________
16. Was worker admitted to hospital? ☐ YES ☐ NO Date ____________ Treated by emergency room only? ☐ YES ☐ NO
    Hospital name and address ____________
17. Name and address of attending physician or clinic ____________
18. Has employee returned to regular duty? ☐ YES ☐ NO Light duty? ☐ YES ☐ NO Date ____________
19. Is compensation now being paid? ☐ YES ☐ NO Date first/initial payment ____________
20. Weekly compensation rate $____________ Is further medical aid needed? ☐ YES ☐ NO ☐ UNKNOWN
21. Did employee die? ☐ YES ☐ NO If YES, give date of death ____________ (File amended report within 28 days if death subsequently occurs.)
22. Name(s) and address(es) of dependents (death cases only) ____________
23. Insurance carrier and third party administrator KWORCC & Tristar Risk Management
    Address PO Box 2805 Clinton IA 52733-2805 Phone (844) 702-2353 Ext 4713
    Street City State ZIP
    Policy number ____________ Name of agent ____________
    Claim number ____________ Name of claim representative Amanda Chamberland
24. Date of report ____________ Completed by ____________ Title ____________