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 (*Street*) Clinton (*City*) IA (*State*) 52733-2805 (*ZIP*) Phone (844) 702-2353 Ext 4713
    Policy number _____ Name of agent _____
    Claim number _____ Name of claim representative Amanda Chamberland
24. Date of report _____ Completed by _____ Title _____