

# EMPLOYER'S REPORT OF ACCIDENT

DIVISION OF WORKERS COMPENSATION  
800 SW JACKSON STE 600  
TOPEKA KS 66612-1227

**Submit  
original  
report only**

**OSHA Case or File Number** \_\_\_\_\_  
There is a \$250 penalty for repeated failure to file Accident Reports within 28 days of the employer's receipt of knowledge of the accident.

**DO NOT WRITE  
IN THIS SPACE**

**READ ATTACHED INSTRUCTIONS BEFORE COMPLETING THIS FORM.**

1- Federal Employer's Identification Number 48-0861452 Date of Hire \_\_\_\_\_

2- Name of Employer Decker Electric, Inc Telephone Number 316-265-8182

3- Mailing Address 4500 W. Harry Wichita KS 67209  
*Street City State Zip Code*

4- Location, if different from mailing address same  
*Street City State Zip Code*

5- Nature of Business Electrical Contractor 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 Code*

8- \_\_\_\_\_  
*Social Security Number Birth Date Employee's Occupation Home Phone Number*

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 & 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 so, give date of death \_\_\_\_\_ *(File amended report within 28 days if death subsequently occurs)*

22- Name and address of dependents (death cases only) \_\_\_\_\_

23- Insurance Carrier and Third Party Administrator Hanover Insurance  
Address PO Box 15144 Worcester MA 01615-0146 800-322-9025  
*Street City State ZIP Phone*  
Policy Number WDT2199562 Name of Agent IMA of Kansas (Mike Maddy)  
Claim Number \_\_\_\_\_ Name of Claim Representative \_\_\_\_\_

24- Date of Report \_\_\_\_\_ Completed by \_\_\_\_\_ Title \_\_\_\_\_

COUNTY

CAUSE

NATURE

SEVERITY

- 0 - NO TIME LOST
- 1 - TIME LOST
- 2 - MEDICAL
- 3 - FATAL

SOURCE

MEMBER

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IN THIS SPACE**