Kansas Association of School Boards
Supervisor's Accident Investigation Report

This report is to be completed by the injured person's supervisor before the end of the shift during which the accident or illness occurred.

NAME OF INJURED PERSON:_____

AGE: _____EMPLOYMENT STATUS FULL-TIME☐ PART-TIME☐ VOLUNTEER☐

DATE OF ACCIDENT:_____DAY OF ACCIDENT:_____TIME:_____A.M. / P.M.

DEPARTMENT:_____OCCUPATION:_____

HOURS INTO SHIFT WHEN OCCURRED:_____HOW LONG EMPLOYED?_____

EXACT LOCATION OF ACCIDENT:_____

WAS ACCIDENT SITE REVIEWED BY SUPERVISOR? Yes☐ No☐

DID SUPERVISOR INTERVIEW INJURED PERSON? Yes☐ No☐

DID SUPERVISOR INTERVIEW WITNESSES? Yes☐ No☐

EXACTLY HOW DID ACCIDENT OCCUR? DESCRIBE PERSONS, ACTION, EQUIPMENT, CONDITIONS, ETC.:

_____

_____

_____

WAS EMPLOYEE WEARING/USING REQUIRED SAFETY EQUIPMENT? Yes☐ No☐ N/A☐

WHAT EQUIPMENT COULD HAVE BEEN UTILIZED TO PREVENT THIS ACCIDENT?

_____

_____

IS THIS EQUIPMENT AVAILABLE FOR EMPLOYEE USE? Yes☐ No☐

FOR EACH OF THE FOLLOWING FACTORS, INDICATE WHAT COULD BE IMPROVED TO PREVENT THIS ACCIDENT:

TRAINING

_____

_____

_____

COMMUNICATIONS

_____

_____

_____

POLICIES/PROCEDURES

_____

_____

_____

INSPECTIONS/OBSERVATIONS

_____

_____

_____

WHAT IMMEDIATE ACTION HAS BEEN TAKEN TO PREVENT THE RECURRENCE OF A SIMILAR ACCIDENT?

_____

REPORT BY INJURED EMPLOYEE ATTACHED? Yes ☐ No ☐

REPORTS OF EYEWITNESSES ATTACHED? Yes ☐ No ☐

WAS FIRST AID ADMINISTERED ON THE SCENE? Yes ☐ No ☐

WHO AUTHORIZED MEDICAL TREATMENT?_____

SUPERVISOR SIGNATURE:_____ DATE:_____

****

TO BE ROUTED TO:

****

TO BE FILLED OUT BY THE DEPARTMENT DIRECTOR

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

TO BE COMPLETED BY SAFETY COORDINATOR

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

TO BE COMPLETED BY SUPERINTENDENT

COMMENTS:_____

_____

_____

SIGNATURE_____ DATE_____

KASB
Workers Compensation Fund, Inc.

REPORT BY INJURED EMPLOYEE

Employer:_____

Your Name:_____

Your Home Address:_____

Your Home Phone Number:_____

Social Security Number:_____

Date of Accident:_____Time of Accident:_____

In your own words, please describe what happened:_____

_____

_____

_____

What physical problems do you relate to this injury?_____

_____

_____

Did you report this injury to your supervisor?_____If not, why not?_____

Date Reported?_____Supervisor's Name:_____

Were you working at your regular job at the time of the injury?_____If not, please explain:

_____

_____

_____

Were there any witnesses?_____If yes, who?_____

_____

Did you go to a hospital/clinic? Yes☐ No☐

Address of hospital/clinic:_____

Name of treating physician:_____

Any additional comments:_____

_____

_____ _____

Date Signature

KASB
Workers Compensation Fund, Inc.

REPORT BY EYEWITNESS

Name:_____

Name of Injured Employee:_____

Name of Witness:_____

Address:_____

Telephone Number:_____

Date of Incident:_____

In your own words, describe what you saw happen:

_____

_____

_____

Did anyone else see the accident? ☐ Yes ☐ No

If yes, please list their name(s)?_____

_____

Other comments:_____

_____

Signature of Eyewitness:_____

CompPBM
PHARMACY MANAGEMENT

6700 Antioch Rd, Ste 120
Merriam, KS 66204

KASB
Workers Compensation Fund, Inc.

KASB Workers Compensation – Pharmacy Benefits Card

KASB Workers Compensation Fund, Inc and CompPBM are providing you with a workers compensation first fill card to use at any network pharmacy for prescriptions related to your work injury. Please present this temporary prescription card in order to fill your prescription. A permanent prescription card will be provided to you by mail.

First Fill Rx Card Limits:

- This card is valid for 10 days
- $100 maximum allowed for approved prescriptions
- 15-day maximum supply

If your prescription falls outside of the above limits, you will need to get prior authorization before the prescription can be filled.

If you have any questions about the workers compensation pharmacy program or you are at the pharmacy and need support, please contact CompPBM at (844) 744-4726.

We appreciate the opportunity to service your prescription benefit needs!

KASB
Workers Compensation Fund, Inc.

KASB Workers Compensation Fund, Inc. RX Program

Member Name:
_____
Member Number:
Last 4 SSN+ 6-digit Date of Injury

Bin: **021031**
PCN: **CPBM**
Group: **88159002**
Person Code: **01**

Pharmacy Help Desk: (844) 744-4726

INFORMATION FOR INJURED EMPLOYEES

K-WC 27-A (Rev. 06-18-24)

* THIS NOTICE APPLIES TO ACCIDENTS ON OR AFTER JULY 1, 2024 *

Employers are required to provide this information to each injured worker.

WHAT TO DO IF AN INJURY OCCURS ON THE JOB

If you have any questions about workers compensation benefits, contact the Division of Workers Compensation at the phone number at the bottom of the page. **Assistance in Spanish is available.**

(1) NOTIFY YOUR EMPLOYER IMMEDIATELY: Per K.S.A. 44-520, a claim may be denied if an employee fails to notify their employer within the earliest of the following dates: (A) 30 calendar days from the date of accident or the date of injury by repetitive trauma; (B) if the employee no longer works for the employer against whom benefits are being sought, 20 calendar days after the employee's last day of actual work for the employer.

Notice may be given orally or in writing. Where notice is provided orally, if the employer has designated an individual or department to whom notice must be given and such designation has been communicated in writing to the employee, notice to any other individual or department shall be insufficient under this section. If the employer has not designated an individual or department to whom notice must be given, notice must be provided to a supervisor or manager.

Where notice is provided in writing, notice must be sent to a supervisor or manager at the employee's principal location of employment.

The notice, whether provided orally or in writing, shall include the time, date, place, person injured and particulars of such injury. It must be apparent from the content of the notice that the employee is claiming benefits under the workers compensation act or has suffered a work-related injury.

(2) FOLLOW YOUR EMPLOYER'S INSTRUCTIONS for getting medical aid and follow the doctor's instructions.

(3) MEDICAL BENEFITS: An injured worker is entitled to all medical services reasonably necessary to cure and relieve the worker from the effects of the injury. The employer has the right to select the doctor who will treat the injury. A worker may seek the services of an unauthorized doctor up to a limit of $800.00. A worker may apply to the Workers Compensation Director to change the authorized treating doctor. Reimbursement for travel to obtain medical treatment is payable at a rate set by law for trips that are five miles or more (round trip).

(4) WEEKLY BENEFITS: Benefits are paid by the employer's insurance carrier or self insurance program. Injured workers are not entitled to compensation for the first week they are off work unless they lose three consecutive weeks. The first compensation payment is normally due at the end of the 14th day of lost time. An injured employee is entitled to a weekly amount of 66 ⅔ percent of his/her average weekly wage up to a maximum of 75 percent of the state's average weekly wage. These benefits are subject to legislative changes. If the injury results in permanent disability, the Kansas Workers Compensation law provides for additional benefits.

RESPONSIBILITIES OF THE EMPLOYER

1. Unless self-insured, the employer must advise its insurance carrier or group-funded pool of employee's injury.

   Per K.S.A. 44-557, it is the duty of every employer to make or cause to be made a report to the director of any accident, or claimed or alleged accident, to any employee which occurs in the course of the employee's employment and of which the employer or the employer's supervisor has knowledge, which report shall be made upon a form to be prepared by the director, within 28 days, after the receipt of such knowledge, if the personal injuries which are sustained by such accidents, are sufficient wholly or partially to incapacitate the person injured from labor or service for more than the remainder of the day, shift or turn on which such injuries were sustained.

As outlined in K.A.R. 51-9-17, all insurance carriers, group pools and self-insurers are required to use Electronic Data Interchange (EDI) to file First Reports of Injury (FROI) and Subsequent Reports of Injury (SROI) using the Release 3.1 Standards. For details contact the Technology and Statistics section of the Division of Workers Compensation at (785) 296-4000 or (800) 332-0353. You may access our website at https://www.dol.ks.gov/workers-compensation/electronic-data-interchange-edi.

2. Employers must provide for the payment of workers compensation claims without any charge to employees.

3. Employers must post the Workers Compensation Notice prepared by the Director.

4. Employers must pay compensation benefits, regardless of insurance coverage.

5. Upon receiving notice of an injury, the employer must provide the employee written information to assist the injured worker in understanding his/her rights and responsibilities in obtaining compensation.

Pursuant to K.S.A. 44-5,102(a)
EMPLOYERS MUST COMPLETE THE FOLLOWING INFORMATION FOR INJURED WORKERS

Your claim will be handled by:

Company KASB Workers Compensation Fund Inc.

Address 1420 SW Arrowhead Road
Topeka, Kansas 66604

Contact Person Liz Maisberger-Clark, Director of Insurance Services

Phone 785-271-4533 **Fax:** 785-273-7870

Email lmaisberger@kasb.org

INFORMACIÓN PARA TRABAJADORES LESIONADOS

K-WC 270-A (Revisado 06-18-24)

* ESTE AVISO APLICA A FECHAS DE ACCIDENTE A PARTIR O DESPUÉS DE Julio 1, 2024 *

Empleadores son requeridos de proveer ésta información a cada trabajador que se lesiona

¿QUÉ HACER SI LE SUCEDE UN ACCIDENTE EN EL TRABAJO?

Si tiene preguntas acerca de beneficios de compensación del trabajador, contacte la unidad mencionada al final de página. **Asistencia en Español está disponible.**

(1) NOTIFIQUE A SU EMPLEADOR INMEDIATAMENTE: De acuerdo con el artículo de la ley K.S.A. 44-520, un reclamo puede ser negado si el empleado no notifica a su empleador antes de las siguientes fechas: (A) 30 días a partir de la fecha del accidente o la fecha de la lesión debido a trauma por movimientos repetitivos; (B) si el empleado ya no trabaja para el empleador en contra del cual se están buscando beneficios, 20 días después del último día de trabajo para dicho empleador.

El aviso puede darse oralmente o por escrito. Donde el aviso se da oralmente, si el empleador ha designado un individuo o departamento a quien el aviso se debe dar y tal designación ha sido comunicada por escrito al empleado, aviso a cualquier otro individuo o departamento deberá ser insuficiente bajo esta sección. Si el empleador no ha designado a un individuo o departamento a quien se debe dar el aviso, el aviso puede darse a un supervisor o gerente.

Donde el aviso se hace por escrito, el aviso debe ser enviado a un supervisor o gerente de la oficina principal de empleo del trabajador.

El aviso, sea que se haga oralmente o por escrito, debe incluir la hora, fecha, lugar, persona lesionada y detalles de tal lesión. Debe ser visible a partir del contenido del aviso, que el empleado está reclamando beneficios bajo la ley de compensación del trabajador o que ha sufrido una lesión relacionada con el trabajo.

(2) SIGA LAS INSTUCCIONES DE SU EMPLEADOR para conseguir ayuda médica y siga las instrucciones del doctor.

(3) BENEFICIOS MÉDICOS: El trabajador lastimado tiene derecho a todo servicio médico razonablemente necesario para curar y aliviar al trabajador de los efectos de la lesión. El empleador tiene el derecho de seleccionar el doctor quien dará el tratamiento necesario. El trabajador tiene derecho de escoger los servicios de otro doctor no autorizado hasta llegar al límite de 800.00 dólares. El trabajador puede solicitar al Director de Compensación de Trabajadores el cambio del doctor autorizado. Los gastos incurridos en viajes hechos para obtener tratamiento médico serán reembolsados según sean estipulados por ley por viajes que incluyen más de cinco millas, viaje redondo.

(4) BENEFICIOS SEMANALES: Los beneficios son pagados por la compañía aseguradora del empleador o programa de seguro propio. Los trabajadores lesionados no tienen derecho a compensación por la primera semana, a menos que estén sin trabajar tres semanas consecutivas.

El primer pago de compensación normalmente se vence al fin de los 14 días de estar sin trabajar. Un trabajador lesionado tiene derecho a una cantidad semanal de 66 2/3 por ciento de su sueldo promedio semanal hasta un máximo de 75 por ciento del sueldo promedio semanal del estado. Estos beneficios están sujetos a cambios por la legislatura. Si la lesión resulta en incapacidad permanente, la ley del Estado de Kansas para Compensación de Trabajadores provee beneficios adicionales.

RESPONSABILIDADES DEL EMPLEADOR

1. A menos que esté auto-asegurado, el empleador debe informar a su compañía de seguros o grupo financiero mancomunado de la lesión el empleado.
   Por K.S.A. 44-557, es deber de cada empleador hacer o causar que se haga un informe al director de cualquier accidente, reclamo o supuesto accidente a cualquier empleado que le ocurra en el curso de su empleo, y del cual el empleador o su supervisor tienen conocimiento, dicho informe deberá ser hecho en un formulario preparado por el director, dentro de los próximos 28 días después de la recepción de dicho conocimiento, si las lesiones sufridas por tales accidentes, son suficientes para incapacitar parcial o totalmente a la persona lesionada ya sea en trabajo de mano de obra o prestando algún servicio por más que el resto del día o turno en el que tales lesiones fueron sufridas.
   Como se describe en K.A.R. 51-9-17, todas las compañías de seguros, grupos mancomunados y auto-asegurados, están obligados a utilizar el Intercambio Electrónico de Datos (EDI, por sus siglas en Ingles) para presentar le Primer Reporte de Accidente (FROI, por sus siglas en Ingles) y Subsecuentes Reportes de Lesiones (SROI, por sus siglas en Ingles) utilizando el Lanzamiento de Nivel 3.1. Puede acceder a nuestro sitio web en http://www.dol.ks.gov/wc/insurer/electronic-data-interchange-(edi)
2. Los empleadores deben suministrar el pago de los reclamos sin costo a los empleados.
3. Los empleadores deben exhibir un Aviso de Compensación al trabajador, preparado por el Director.
4. Los empleadores deben pagar beneficios de compensación sin importar la cobertura de seguro.
5. Tan pronto como se reciba el aviso de una lesión, el empleador debe proveer información por escrito para ayudar al trabajador lesionado a entender sus derechos y responsabilidades al obtener compensación.

Conforme a la Ley K.S.A. 44-5,102(a)
EMPLEADORES DEBEN COMPLETAR LA SIGUIENTE INFORMACIÓN PARA LOS TRABAJADORES LESIONADOS

SU RECLAMO SERÁ MANEJADO POR:

Compañía KASB Workers Compensation Fund, Inc.

Dirección 1420 SW Arrowhead Road

Topeka, KS 66604

Persona de Contacto Liz Maisberger-Clark, Director of Insurance Operations

Teléfono (785) 271-4533 **Fax** (785) 273-7870

Correo electrónico lmaisberger@kasb.org