Reporting worker compensation claims

If the employee needs emergency medical care, call 911.

If the injury does not require an ambulance, employees should be sent for treatment to Stormont Vail Work Care. The Clinic is located at 1504 SW 8th Ave. at the west entrance of the Kansas Rehabilitation Hospital. Phone Number – (785) 270-8605.

The Work Care clinic is open from 8am-5pm Monday - Friday. If arriving by ambulance, after hours, or on a weekend, please report to the Stormont Vail Emergency Room.

Reporting accidents: If the accident occurs between the hours of 8:00am to 4:00pm during the workweek the supervisor, MIC, or Security completes the Accident Report (see below) as soon as possible and forwards it to both Jesse Maddox and Felicia Hillebert in Human Resources. Unknown information should be left blank; do not delay reporting the accident just to fill in a blank form line. Accidents requiring medical treatment must be reported to Cincinnati Insurance by telephone within 24 hours.

On weekends the MIC or Security is responsible for making the call.

If medical treatment beyond first aid is not necessary, the claim does not need to be called in to the Insurance Carrier.

If medical treatment is needed, HR will usually call in the claim to the insurance carrier.

Reporting Worker Compensation Claims to Cincinnati Insurance

Call toll-free, anytime day or night: **877-242-2544.**

Please have claim-related information ready (from the TSCPL Accident Report below)

Employer Information:

- Policyholder: Topeka & Shawnee County Public Library.
- Policy number: WC 0363174

Employee Information (obtain from Accident Report):

- Name, address, phone number.
- Social Security Number
- Date of birth
- Gender
- Current position
- Marital status (HR will provide later)
- Number of dependents (HR will provide later)
- Hire date (HR will provide later)
- Wage information (HR will provide later)

Incident Information (Obtain from Accident Report)

- Type of Injury (such as burn or cut)
- Specific body part injured (such as left arm or right hand)
- Cause of accident
- Names of witnesses
- Address where injury occurred
- Where the injured employee was treated
- When the accident was reported to you and by whom

ACCIDENT REPORT

Complete and Email to HR within one workday.

TOPEKA & SHAWNEE COUNTY PUBLIC LIBRARY

Claim Information

Injured Employee Name:

Home Address: (Street)	(City)	(State)	(Zip)

Home Phone Number:	Gender: Male ☐ Female ☐	Date of Birth:
Occupation:	Department Name:	

Supervisor Name & Phone Number:

Date/Time of Injury: ☐ AM ☐ PM	Time Workday Began:

Did the accident occur at the library? ☐ Yes ☐ No

If no, where did the accident occur? (Street)	(City)	(State)	(Zip)

Give a full description of how the accident occurred.

Date and Time of this report	Person Reported To:

Injury Description:

Date of Death (if applicable):	Is Employee Hospitalized? ☐ Yes ☐ No
Which part of the body was injured? (e.g. Head, Neck, Arm, Leg)	Part of Body Location: (e.g. Left, Right, Upper, Lower)
Has the employee lost time? ☐ Yes ☐ No	If yes, when was the first full day out?

Expected Return to Work:

Medical Treatment Information

Initial Medical Treatment: (select one)

☐ No Medical Treatment
☐ Minor/Onsite
☐ Physician/Clinic
☐ ER Treated and Released
☐ Hospitalized

Hospital:

(Name) (Address) (Phone Number)

Clinic/Doctor:

(Name) (Address) (Phone Number)

Witness Information

Were there any witnesses? ☐ Yes ☐ No

If yes, list names and how to contact them.

Report Prepared By

Name:	Title:
Signature:	Phone Number:

Comments