FORT HAYS STATE UNIVERSITY
Forward thinking. World ready.

State Self Insurance Fund
Work-Related Injuries
(Employee Claim Form)

Employees must report the work-related injury to their supervisor as soon as possible. A delay in reporting may cause the claim to be denied. The Human Resource Office is responsible for filing the claim through the SSIF portal. Please complete the following information and send this form to the Human Resource Office as soon as possible.

GENERAL

Date of Injury/Illness _____ Time of Injury/Illness: _____

EMPLOYEE

Employee Name _____
(First) (MI) (Last)

DOB _____ **State of Kansas** Employee ID# _____

Physical Address _____
(Address) (City) (State) (Zip)

Mailing Address _____
(Address) (City) (State) (Zip)

Separate Mailing Address? ☐ Yes ☐ No Employee E-mail _____

Employee Work Phone _____ Employee Mobile Phone _____

Employee Home Phone _____

EMPLOYMENT

Date of Hire _____ Hours per Day _____ Days per Week _____

Supervisor's Name _____

Supervisor's Work Phone _____ Supervisor's E-mail _____

(Continue to page 2)

LOSS OF LIFE

Death Result of Injury? ☐ Yes ☐ No Date of Death _____

Marital Status _____ Number of Dependents _____

OCCURRENCE

Time Employee Began Work _____ Accident Premises ☐ Yes ☐ No

Date Supervisor/Employer Notified _____ Body Part (primary if multiple) _____

Cause of Injury _____ Nature of Injury _____

Description of How Injury/Illness Occurred _____

_____

_____

Injury Address _____
(Address) (City) (State) (Zip)

Witness Name (if applicable) _____ Witness Phone # _____

TREATMENT

Medical Treatment Sought? _____
(No Treatment; Minor Clinic; Emergency Room; Hospitalization; Minor On-Site; Future Major Medical)

SSIF Prior Medical Approval ☐ Yes ☐ No

Physician Name _____
(First) (MI) (Last)

Physician Address _____
(Address) (City) (State) (Zip)

Hospital Name _____