# Kansas Building Industry Workers' Compensation Fund

2101 SW 36th Street
Topeka, KS 66611
Phone: 785-266-4540 Fax: 785-266-7953

**PLEASE PRINT DO NOT TYPE**

**Employee Statement**

*Claim No:*_____

Last Name: _____ First Name: _____ MI: _____ Social Sec. No: _____-____-_____

Home Address: _____ City:_____ State:_____ ZIP:_____

Home Phone: (  )_____ Cell Phone: (  )_____

*Incident Statement:*

Be sure to include the location of the accident, date and time, witnesses, physical injury, how it happened and all other related information (use additional pages if needed):

The information above is an accurate description of the sequence of events that led up to the injury that I sustained while performing my required job duties

Print Name _____ Signature _____ Date ____/____/_____

Revised 4/21/2011