KANSAS DEPARTMENT OF LABOR
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REPORT OF FRAUD OR ABUSE (CONFIDENTIAL)

K-WC 44 (11-16)

MAIL: Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105

FAX: (785) 296-7710

NOTE: You may choose to submit this form anonymously; however, this may limit the scope of the investigation.

Date of report: _____

Your name: _____ SSN: _____ Date of birth: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: (____) _____ Email: _____

Name of person or entity suspected of committing fraud or abuse: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: (____) _____ Email: _____

Identifying information if applicable and available (not required): SSN: _____ Date of birth: _____

Driver's license: _____ Other (e.g., FEIN, etc.): _____

Name of person or entity the fraud or abuse was committed against: _____

Street: _____ City: _____ State: _____ ZIP: _____

Phone: (____) _____ Email: _____

Identifying information if applicable and available (not required): SSN: _____ Date of birth: _____

Driver's license: _____ Other (e.g., FEIN, etc.): _____

County in which the accidental injury, repetitive trauma or occupational disease occurred: _____

Date(s) on which the accidental injury, repetitive trauma or occupational disease occurred: _____

_____

Give details below of the fraudulent or abusive act(s). Attach additional pages if necessary.
Supporting documentation: ☐ Attached ☐ Can submit upon request