

Nebraska Worker's Compensation Court

NWCC Form I
Revised 03-02

First Report of Alleged Occupational Injury or Illness

Employer			
Employer FEIN: 47-0491233		UI#	SIC Code:
Business Name(s): State of Nebraska Address: 521 S. 14 th , Suite 104 City: Lincoln State: NE Zip Code: 68508 Phone: 402-471-2551		Insured Name (If different from employer name) (Agency Name)	
		Employer's Location Address (If different):	Location
Insurance Carrier			
Carrier FEIN: 47-0491233		Admin. FEIN: 72-0837383	
Name: State of Nebraska Address: 521 South 14 th , Suite 104 City: Lincoln State: NE Zip Code: 68508 Phone: 402-471-2551		Claim Administrator (Name, address & phone number): FARA 9140 W. Dodge Rd Suite 418 Omaha, NE 68114 866-599-3272	
Policy Number: N/A Policy Period: From: N/A To: N/A		Check if Appropriate Self Insured <input checked="" type="checkbox"/> TPA <input checked="" type="checkbox"/>	Carrier/Claim Administrator Claim # Jurisdiction Claim #
Insurance Carrier/Self-Insured Code #:		Insured Report #	Jurisdiction:
Employee			
Name (Last, First, Middle):		Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/> Salary Cont. Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days Worked Per Week:
Address:		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>	Occupational Job Title:
City:		Number of Dependents:	Occupational Code:
State: Zip Code: Phone:		Marital Status	Wage \$
Date of Birth: Social Security No.: Date Hired:		Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown <input type="checkbox"/>	Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>
		Date Employee Began Work-Related Duties:	Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>
Occurrence/Treatment			
Date of Injury/Illness	Time Employee Began Work AM <input type="checkbox"/> PM <input type="checkbox"/>	Time of Occurrence AM <input type="checkbox"/> PM <input type="checkbox"/> (Cannot be determined) <input type="checkbox"/>	Last Work Date
Where Did Injury/Illness Occur? County: State: Zip:		Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/> Location:	
Date Employer Notified	Date Disability Began	Date Returned to Work	If Fatal, Give Date of Death
Type of Injury/Illness (Briefly describe the nature of the injury or illness; eg. lacerations to forearm)			Nature of Injury Code
Part of Body Affected (Indicate the part of the body affected by the injury/ illness; eg. right forearm, lowerback; and how it was affected)			Part of Body Code
How Injury/Illness Occurred (Describe the activity and tools, materials, equipment the employee was using; how injury occurred)			Cause of Injury Code
Initial Treatment		Name or physician or other health care provider:	
No Medical Treatment <input type="checkbox"/> Emergency Care <input type="checkbox"/> Future Major First Aid By Employer <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> Medical/Lost Minor Clinic/Hospital <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/> Time <input type="checkbox"/>			
Date Administrator Notified	Form Preparer's Name, Title and Phone		Date Prepared



WORKERS' COMPENSATION INCIDENT REPORT

Print Employee's Name _____ Today's Date _____

Personnel # _____ Phone where you can be reached _____

Employer _____ Supervisor _____

INCIDENT INFORMATION

Date of Injury _____ Time _____ am pm Date Reported _____

To Whom Reported? _____ Did you miss time from work for the injury? Yes No

If yes, give dates and times _____

Returned to Work? Yes/No Full Duty/Light Duty **If no**, date expect to return? _____

What part of your body was injured? (*Right leg, left arm*) _____

What is the injury? (*Cut, Sprain, Bruise*) _____

Explain in detail how the injury occurred? _____

Where did the injury occur? (*Physical location*) _____

Any Witnesses? Yes No **If yes**, give names _____

Did you seek medical treatment? Yes No **If yes**, give date & time

Doctor's name _____ Return visit date _____

What type of treatment are you getting? _____

How are you getting along now? _____

Have you ever injured this part of your body before? Yes No

If yes, explain when, how and to what extent: _____

What would you do to prevent this from happening again? _____

Signature of Employee _____ Date _____

EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

NOTICE TO EMPLOYER: GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

A: RIGHTS OF THE EMPLOYEE

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

You may use part B below to tell your employer the name of the doctor you choose.

B: CHOICE OF DOCTOR

I choose the following doctor to treat me for this work related injury. I certify that this doctor has treated me or an immediate family member before the work related injury.

I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

DOCTOR'S NAME

SIGNATURE OF EMPLOYEE

DOCTOR'S ADDRESS

DATE

C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work related injury. I certify the doctor named below has treated me or an immediate family member before this work related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

DOCTOR'S NAME

SIGNATURE OF EMPLOYEE

DATE

DOCTOR'S ADDRESS

SIGNATURE OF EMPLOYER

DATE