

# Nebraska Worker's Compensation Court

NWCC Form I  
Revised 03-02

## First Report of Alleged Occupational Injury or Illness

<b>Employer</b>			
Employer FEIN: 47-0491233		UI#	SIC Code:
Business Name(s): State of Nebraska Address: 521 S. 14 <sup>th</sup> , 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
<b>Insurance Carrier</b>			
Carrier FEIN: 47-0491233		Admin. FEIN: 36-2685608	
Name: State of Nebraska Address: 521 South 14 <sup>th</sup> , Suite 104 City: Lincoln State: NE Zip Code: 68508 Phone: 402-471-2551		Claim Administrator (Name, address & phone number):  Cambridge Integrated Service Group, Inc.	
Policy Number: N/A Policy Period: From: N/A To: N/A		<b>Check if Appropriate</b> 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:
<b>Employee</b>			
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"/>
<b>Occurrence/Treatment</b>			
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