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. 14th, 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 14th, Suite 104
City: Lincoln
State: NE Zip Code: 68508 Phone: 402-471-2551
Policy Number: N/A
Policy Period: From: N/A To: N/A

Insurance Carrier/Self-Insured Code #:

Claim Administrator *(Name, address & phone number):*
FARA
9140 W. Dodge Rd Suite 418
Omaha, NE 68114
866-599-3272

Check if Appropriate	Carrier/Claim
Self Insured ☒	Administrator Claim #
TPA ☒	Jurisdiction Claim #

Insured Report # Jurisdiction:

Employee

Name ***(Last, First, Middle***):
Address:
City:
State: Zip Code: Phone:
Date of Birth: Social Security No.: Date Hired:

Full Pay for DOI Yes ☐ No ☐
Salary Cont. Yes ☐ No ☐

Number of Days Worked Per Week:

Sex: Male ☐ Female ☐

Number of Dependents:

Occupational Job Title:

Marital Status
Married ☐
Separated ☐
Unmarried ☐
Unknown ☐

Wage $
Hourly ☐
Daily ☐
Weekly ☐
Bi-Weekly ☐
Monthly ☐

Occupational Code:

Date Employee Began Work-Related Duties:

Employment Status
FT ☐ PT ☐ Other ☐

Occurrence/Treatment

Date of Injury/Illness	Time Employee Began Work AM ☐ PM ☐	Time of Occurrence AM ☐ PM ☐ (Cannot be determined) ☐	Last Work Date

Where Did Injury/Illness Occur?
County: State: Zip:

Did Injury/Illness Occur On Employer's Premises?
Yes ☐ No ☐ 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

No Medical Treatment ☐	***Emergency Care*** ☐	***Future Major*** ☐	***Name or physician or other health care provider:***
First Aid By Employer ☐	***Hospitalized overnight*** ☐	***Medical/Lost*** ☐	
Minor Clinic/Hospital ☐	***Hospitalized > 24 Hours*** ☐	***Time*** ☐	

Date Administrator Notified	Form Preparer's Name, Title and Phone	Date Prepared

University of Nebraska Lincoln

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

PART A: NOTICE REGARDING CHOICE OR CHANGE OF DOCTOR

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.

☐ My employer has informed me of the above information regarding choice or change of doctor.

[SIGNATURE OF EMPLOYEE] [DATE]

PART 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]

PART 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 OF SIGNATURE]

[DOCTOR'S ADDRESS] [SIGNATURE OF EMPLOYER & DATE OF SIGNATURE]