

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 03-02

Employer					
Employer FEIN _____		SIC Code _____		Report Purpose _____ OSHA Log Case # _____	
Employer Name(s) _____			Insured Name <i>(If different from employer name)</i> _____		
Address _____			Insured Address <i>(If different)</i> _____		
City _____			Location _____		
State _____		Zip Code _____		Phone _____	
Insurance Carrier					
Carrier FEIN _____			Administrator FEIN _____		
Name _____			Claim Administrator <i>(Name, address & phone number)</i> _____		
Address _____			_____		
City _____			_____		
State _____		Zip Code _____		Phone _____	
Policy Number _____			Self Insured <input type="checkbox"/> Claim Administrator Claim # _____		
Policy Period: From _____ To _____			Check if <i>Appropriate</i> Jurisdiction Claim # _____		
Insurance Carrier/Self-Insured Code # _____			Insured Report # _____		Jurisdiction _____
Employee					
Name <i>(Last, First, Middle)</i> _____			Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Days Sex Male <input type="checkbox"/>
Address _____			Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>		Worked Per Week _____ Female <input type="checkbox"/>
City _____			Number of Dependents _____		Occupational Job Title _____
State _____			Marital Status _____		Occupational Code _____
Zip Code _____			Wage \$ _____		Date Employee Began _____
Phone _____			Married <input type="checkbox"/> Hourly <input type="checkbox"/>		Work-Related Duties _____
Date of Birth _____			Separated <input type="checkbox"/> Daily <input type="checkbox"/>		Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>
Social Security Number _____			Unmarried <input type="checkbox"/> Weekly <input type="checkbox"/>		_____
Date Hired _____			Unknown <input type="checkbox"/> Bi-Weekly <input type="checkbox"/>		_____
_____			Monthly <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"/>	
Where Did Injury/Illness Occur?		Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>			
County _____ State _____ Zip _____		Date Employer Notified _____		Date Disability Began _____	
Date Employer Notified _____		Date Disability Began _____		Date Returned to Work _____	
Type of Injury/Illness <i>(Briefly describe the nature of the injury or illness; e.g. lacerations to forearm)</i>					Nature of Injury Code _____
Part of Body Affected <i>(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)</i>					Part of Body Code _____
How Injury/Illness Occurred <i>(Describe activity and tools, materials, equipment the employee was using; how injury occurred)</i>					Cause of Injury Code _____
Initial Treatment: No medical treatment <input type="checkbox"/> Emergency Room <input type="checkbox"/> Future major medical/lost time <input type="checkbox"/>			Name of physician or other health care provider: _____		
First aid by employer <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/>			_____		
Minor clinic/hospital <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/>			_____		
Date Administrator Notified _____		Form Preparer's Name, Title and Phone _____			Date Prepared _____