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) _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Insured Name *(If different from employer name)*

Insured Address *(If different)*

Location _____

Insurance Carrier

Carrier FEIN _____

Name _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Policy Number _____

Policy Period: From _____ To _____

Insurance Carrier/Self-Insured Code # _____

Administrator FEIN _____

Claim Administrator *(Name, address & phone number)*

Self Insured ❑

Check if Appropriate

Claim Administrator Claim # _____

Jurisdiction Claim # _____

Insured Report # _____

Jurisdiction _____

Employee

Name *(Last, First, Middle)* _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Date of Birth | Social Security Number | Date Hired

Full Pay for DOI Yes ❑ No ❑
Salary Continued Yes ❑ No ❑

Number of Days Worked Per Week _____

Sex Male ❑ Female ❑

Number of Dependents _____

Marital Status
Married ❑
Separated ❑
Unmarried ❑
Unknown ❑

Wage $ _____
Hourly ❑
Daily ❑
Weekly ❑
Bi-Weekly ❑
Monthly ❑

Occupational Job Title

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 (Cannot be determined ❑) AM ❑ PM ❑

Last Work Date

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

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

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; e.g. lacerations to forearm)*

Nature of Injury Code

Part of Body Affected *(Indicate the part of the body affected by the injury/illness; e.g. right forearm, lowerback; and how it was affected)*

Part of Body Code

How Injury/Illness Occurred *(Describe activity and tools, materials, equipment the employee was using; how injury occurred)*

Cause of Injury Code

Initial Treatment:
No medical treatment ❑
First aid by employer ❑
Minor clinic/hospital ❑
Emergency Room ❑
Hospitalized overnight ❑
Hospitalized > 24 hours ❑
Future major medical/lost time ❑

Name of physician or other health care provider:

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