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 _____

Administrator FEIN _____

Name _____

Address _____

_____

City _____

State _____ Zip Code _____ Phone _____

Policy Number _____

Policy Period: From _____ To _____

Insurance Carrier/Self-Insured Code # _____

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

General Instructions

Items in bold are mandatory fields. First Report of Injury or Illness (*FROI*) without this information will be returned.

Item—Definitions

Employer:

- Employer FEIN—the employer/insured's Federal Employer's Identification Number.
- SIC Code—**S**tandard **I**dentification **C**lassification code which represents the nature of the employer's business.
- Report Purpose—defines the specific purpose of the transaction. (Examples: original=00; cancel=01; change=02; denial;=04; correction=co).
- OSHA Log Case #—the Log Case number required for reporting to OSHA.
- **Employer Name—include all business names/doing business as *(dba)***
- Address (including city,state,zip)—the address of the employer's actual location where the employee was employed at the time of the injury.
- Phone—phone number at the employer's facility.
- **Insured Name (*if different from employer*)—the named insured on the policy or the financially responsible self–insured employer.**
- Insured Address (***if different***)—mailing address of the insured.
- Location—a code defined by the insured/employer which is used to identify the employer's location.

Insurance Carrier:

- **Carrier FEIN—carrier's Federal Employer's Identification Number.**
- Administrator FEIN—administrator's Federal Employer's Identification Number.
- **Name—the worker's compensation insurer, approved self insured, or intergovernmental risk management pool.**
- **Address— address of insurer (including city, state, zip).**
- Phone—phone number of insurer.
- Claim Administrator (name, address, & phone)—enter the name, address and phone number of the carrier, third party administrator, risk management pool, or self–insurer responsible for administering the claims, if different from carrier information.
- Policy #—the number assigned to the contract/policy for that employer.
- Policy Period—the effective and expiration dates of the contract.
- Insurance Carrier/Self Insured Code #—for insurance carriers, the number assigned by the Nat'l Assn. of Insurance Commissioners. For self-insured employers, the code number assigned by the court.
- **Self Insured—check if appropriate.**
- **Claim Administrator Claim #—identifies a specific claim within a claim administrator's claims processing system.**
- Jurisdiction Claim #—number assigned by the court when the initial First Report is accepted.
- Insured Report #—a number used by the insured to identify a specific claim.
- Jurisdiction—the governing body or territory whose statutes apply (NE).

Employee:

- **Name—give full name as shown on payroll. (Avoid initials if possible).**
- **Address—enter employee's current city and state.** (Address and zip code information is optional)
- Date of Birth—the date the injured worker was born.
- **Social Security Number.**
- Date Hired—the date the injured worker began his/her employment with the employer.
- Full Pay for DOI (date of injury)—check one.
- Salary Continued—check one.
- Number of Days Worked Per Week—the number of the employee's regularly scheduled work days per week.
- Sex—check one.
- Number of Dependents—the number of dependents as defined by the administering jurisdiction.
- Marital Status—check one.
- Wage—check one and state wage.
- Occupational Job Title—the primary occupation of the claimant at the time of the accident.
- Occupational Code—Standard Occupational Classification code used to identify the primary occupation of the employee at the time of the accident.
- Date Employee Began Work–Related Duties—date pertaining to employee's present occupation.
- Employment Status—check one.

Occurrence/Treatment:

- **Date of Injury/Illness—date on which the accident occurred**.
- Time Employee Began Work—time employee began work for that date.
- Time of Occurrence—time of day the injury occurred.
- Last Work Date—the last paid work day prior to the initial date of disability.
- **Where Did Injury/Illness Occur—complete county, state, and zip code.**
- Did Injury/Illness Occur On Employer's Premises—check one.
- Date Employer Notified—the date that the injury was reported to a representative of the employer.
- Date Disability Began—if not disabled answer none and skip questions.
- Date Returned to Work—if injured has returned to work, complete this question.
- **If Fatal, Give Date of Death**, (Conditional if employee died as a result of a work-related injury.)
- **Type of Injury/Illness—describe the nature of injury.**
- Nature of Injury Code—the code which corresponds to the nature of the injury sustained by the employee.
- Part of Body Affected—the part of the body to which the employee sustained injury.
- Part of Body Code—the code which corresponds to the Part of the body to which the employee sustained injury.
- **How Injury/Illness Occurred—a free-form description of how the accident occurred and the resulting injuries.**
- **Cause of Injury Code—the code that corresponds to the cause of injury**
- Initial Treatment—check one.
- Name of physician or other health care provider—provide name of physician or other health care provider that treated employee for injury.
- Date Administrator Notified—the date the claim administrator who is processing the claim received notice of the loss or occurrence.
- Form Preparer's Name, Title and Phone.
- Date Prepared—date form was actually completed.

Type or print neatly your response in ink.