Nebraska Workers' Compensation Court

NWCC Form 1
Revised 03-02

First Report of Alleged Occupational Injury or Illness

Employer

Employer FEIN________________ SIC Code__________ Report Purpose__________ OSHA Log Case #______________

Employer Name(s)______________________

Address______________________

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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______________________

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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______________________

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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 ______

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 ❑

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.