

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 14/2033

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> _____			Location _____			
City _____										
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 _____				<i>Check if 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 Worked Per Week _____		Sex Male <input type="checkbox"/>		Female <input type="checkbox"/>
Address _____				Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>						
City _____				Number of Dependents _____		Occupational Job Title _____				
State _____				Marital Status		Wage \$ _____		Occupational Code _____		
Zip Code _____				Married <input type="checkbox"/>		Hourly <input type="checkbox"/>		NCCI Class Code _____		
Phone _____				Separated <input type="checkbox"/>		Daily <input type="checkbox"/>		Date Employee Began _____		
Date of Birth _____				Unmarried <input type="checkbox"/>		Weekly <input type="checkbox"/>		Work-Related Duties _____		
Social Security Number _____		Date Hired _____		Unknown <input type="checkbox"/>		Bi-Weekly <input type="checkbox"/>		Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <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"/>		Last Work Date _____		
						(Cannot be determined <input type="checkbox"/>				
Where Did Injury/Illness Occur? County _____ State _____ Zip _____					Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Date Employer Notified _____			Date Disability Began _____			Date Returned to Work _____		If Fatal, Give Date of Death _____		
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 _____			

General Instructions

Underlined items are mandatory fields. A first report of injury or illness submitted without this information will be returned unfiled.

Employer:

- Employer FEIN — the employer/insured's Federal Employer's Identification Number.
 - SIC Code — Standard Identification Classification 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, and zip code) — 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 from employer*) — mailing address of the insured.
 - Location — a code defined by the insured/employer which is used to identify the employer's location.
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Insurance Carrier:

- Carrier FEIN — carrier's Federal Employer's Identification Number.
 - Administrator FEIN — administrator's Federal Employer's Identification Number.
 - Name — the workers' compensation insurer, approved self insured, or intergovernmental risk management pool.
 - Address — address, city, state and zip code of insurer.
 - 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/policy.
 - 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).
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Employee:

- Name — give full name as shown on payroll (avoid initials if possible).
 - Address — address, city, state and zip code of employee.
 - Social Security Number. The social security number must be provided. This is mandatory pursuant to Neb.Rev.Stat. §48-144, Rule 29 of the Workers' Compensation Court Rules of Procedure, and Section 7(a)(2)(B) of the Privacy Act of 1974. The social security number is used by the Nebraska Workers' Compensation Court for purposes of verifying the identity of the employee and administering the Nebraska Workers' Compensation Act. It is a unique identifier and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by social security number. The social security number may also be shared with claims handling entities for purposes of processing a claim for workers' compensation benefits and verifying the identity of the claimant.
 - Date of Birth — the date the injured worker was born.
 - 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 Nebraska Workers' Compensation Act.
 - 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.
 - NCCI Code — The identifying number for an occupational classification.
 - Date Employee Began Work-Related Duties — date pertaining to employee's present occupation.
 - Employment Status — check one.
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Occurrence/Treatment:

- Date of Injury/Illness — date on which the accident occurred (*only one date of injury per form*).
- 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, (date employee died as a result of the 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.