

# Nebraska Worker's Compensation Court

NWCC Form I  
Revised 03-02

## First Report of Alleged Occupational Injury or Illness

Employer					
Employer FEIN: 47-0491233		UI#		SIC Code:	
Business Name(s): (agency name) Address: (agency address) City: (city) State: NE Zip Code: (zip) Phone: (agency phone)			Insured Name <i>(If different from employer name)</i>  State of Nebraska		
			Employer's Location Address <i>(If different):</i>		Location
Insurance Carrier					
Carrier FEIN: 47-0491233			Admin. FEIN: 72-0837383		
Name: State of Nebraska Address: 521 South 14 <sup>th</sup> , Suite 104 City: Lincoln State: NE Zip Code: 68508 Phone: 402-471-2551			Claim Administrator <i>(Name, address &amp; phone number):</i> F.A. Richard & Associates, Inc. (FARA) 9140 West Dodge Rd., Suite 418 Omaha, NE 68114		
Policy Number: N/A Policy Period: From: N/A To: N/A			<b>Check if Appropriate</b> Self Insured <input checked="" type="checkbox"/>  TPA <input checked="" type="checkbox"/>		Carrier/Claim Administrator Claim #  Jurisdiction Claim #
Insurance Carrier/Self-Insured Code #:			Insured Report #		Jurisdiction:
Employee					
Name: (last, first, middle)		Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/> Salary Cont. Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Days Worked Per Week:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Address:		Number of Dependents:		Occupational Job Title:	
City:		Marital Status		Wage \$	Occupational Code:
State: Zip: Phone:		Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown <input type="checkbox"/>		Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>	Date Employee Began Work-Related Duties:
Date of Birth	Social Security Number	Date Hired	Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <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"/> (Cannot be determined) <input type="checkbox"/>	Last Work Date
Where Did Injury/Illness Occur? County: State: Zip:			Did Injury/Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/> Location:		
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; eg. lacerations to forearm)</i>					Nature of Injury Code
Part of Body Affected <i>(Indicate the part of the body affected by the injury/ illness; eg .right forearm, lowerback; and how it was affected)</i>					Part of Body Code
How Injury/Illness Occurred <i>(Describe the 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 Care <input type="checkbox"/> Future Major Medical/Lost Time <input type="checkbox"/> First Aid By Employer <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> Name or physician or other health care provider: Minor Clinic/Hospital <input type="checkbox"/> Hospitalized > 24 Hours <input type="checkbox"/>					
Date Administrator Notified		Form Preparer's Name, Title and Phone			Date Prepared