NEBRASKA
Good Life. Great Service.
DEPT. OF ADMINISTRATIVE SERVICES

Employee Incident Report

This form must be completed, reviewed with a supervisor and submitted to WCC within 24 hours.

Employee Name (last, first) _____ EE#/SS#:_____ DOB: _____

Address:_____ Job Title: _____ Hire Date: _____

City: _____ State:_____ Zip: _____ Department: _____

Phone/Cell Number: _____ Supervisor: _____

Date of Injury/Illness:_____ Time Employee Began Work:_____ Time of Injury/Illness: _____

Location of Incident: _____ Who was Notified? _____

Date Employer Notified: _____ Last Work Day: _____ Date Returned to Work: _____

Body Part Injured: _____ If Fatal, Date of Death: _____

Describe incident (describe what happened, how the incident occurred, include details pertaining to equipment, environment, tasks, etc.)

_____

_____

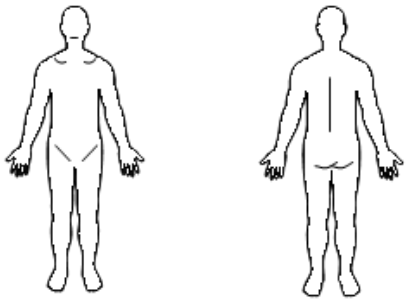
_____

_____

_____

_____

Indicate on the Diagram the location of injury



Injury is a: ☐ New or ☐ Re-injury

Initial Treatment:
- No Medical Treatment: ☐
- First Aid by Employer: ☐
- Minor Clinic/Hospital: ☐
- Emergency Room: ☐
- Hospitalized Overnight: ☐
- Hospitalized >24 Hours: ☐

What was the cause of this incident?

_____

How could this incident have been prevented?

_____

_____

Did anyone witness the incident? ☐ Yes ☐ No

If yes, please provide the name and phone number of the witnesses.

_____

_____

Do you have other employment? ☐ Yes ☐ No If yes, where? _____

_____ _____

Employee Signature Date

Revised 2/16/18