Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 12/2011

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 _____

Occupational Job Title

Marital Status
Married ☐
Separated ☐
Unmarried ☐
Unknown ☐

Wage $ _____
Hourly ☐
Daily ☐
Weekly ☐
Bi-Weekly ☐
Monthly ☐

Occupational Code _____

NCCI Class 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