Nebraska Workers' Compensation Court
First Report of Alleged Occupational Injury or Illness

NWCC Form I
Revised 03-02

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

Marital Status
Married ☐
Separated ☐
Unmarried ☐
Unknown ☐

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

Occupational Job Title

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; eg. lacerations to forearm)*** | Nature of Injury Code

Part of Body Affected ***(Indicate the part of the body affected by the injury/illness; eg. 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 Care ☐
Hospitalized overnight ☐
Hospitalized > 24 ☐
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