

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 11/2006

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 _____		Self Insured <input type="checkbox"/>		Claim Administrator Claim # _____		
Policy Number _____				<i>Check if Appropriate</i>		Jurisdiction Claim # _____				
Policy Period: From _____ To _____				Insured Report # _____				Jurisdiction _____		
Insurance Carrier/Self-Insured Code # _____										
Employee										
Name <i>(Last, First, Middle)</i> _____				Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/>		Salary Continued 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 \$ _____	Hourly <input type="checkbox"/>		Occupational Code _____		
State _____				Zip Code _____	Phone _____	Married <input type="checkbox"/>	Daily <input type="checkbox"/>	NCCI Class Code _____		
Date of Birth _____				Social Security Number _____		Date Hired _____		Unmarried <input type="checkbox"/>	Weekly <input type="checkbox"/>	Date Employee Began _____
				Unknown <input type="checkbox"/>	Bi-Weekly <input type="checkbox"/>	Work-Related Duties _____		Monthly <input type="checkbox"/>	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"/>		Time of Occurrence		AM <input type="checkbox"/>		Last Work Date _____
		PM <input type="checkbox"/>		(Cannot be determined <input type="checkbox"/>		PM <input type="checkbox"/>				
Where Did Injury/Illness Occur?				Did Injury/Illness Occur On Employer's Premises?						
County _____		State _____		Zip _____		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"/>		time <input type="checkbox"/>				
Date Administrator Notified _____		Form Preparer's Name, Title and Phone _____					Date Prepared _____			

General Instructions (Item—Definitions)

Items in bold are mandatory fields. First Report of Injury or Illness (FROI) without this information will be returned.

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.

Insurance Carrier:

- **Carrier FEIN**—carrier's Federal Employer's Identification Number.
- Administrator FEIN—administrator's Federal Employer's Identification Number.
- **Name**—the worker's 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).

Employee:

- **Name**—give full name as shown on payroll (avoid initials if possible).
- **Address**— address, city, state and zip code of employee.
- Date of Birth—the date the injured worker was born.
- **Social Security Number.**
- 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.

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.
- Date Prepared—date form was actually completed.

Type or print neatly your response in ink.