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): State of Nebraska

Address: 521 S. 14th, Suite 104

City: Lincoln

State: NE Zip Code: 68508 Phone: 402-471-2551

Insured Name *(If different from employer name)*
(Agency Name)

Employer's Location Address *(If different)*: Location

Insurance Carrier

Carrier FEIN: 47-0491233

Name: State of Nebraska

Address: 521 South 14th, Suite 104

City: Lincoln

State: NE Zip Code: 68508 Phone: 402-471-2551

Policy Number: N/A

Policy Period: From: N/A To: N/A

Insurance Carrier/Self-Insured Code #:

Admin. FEIN: 72-0837383

Claim Administrator *(Name, address & phone number)*:
FARA
9140 W. Dodge Rd Suite 418
Omaha, NE 68114
866-599-3272

Check if Appropriate	Carrier/Claim
Self Insured ☒	Administrator Claim #
TPA ☒	Jurisdiction Claim #

Insured Report # Jurisdiction:

Employee

Name *(Last, First, Middle)*:

Address:

City:

State: Zip Code: Phone:

Date of Birth: Social Security No.: Date Hired:

Full Pay for DOI Yes ☐ No ☐
Salary Cont. 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:

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 ☐ Location:

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 the 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 Hours ☐
Future Major Medical/Lost Time ☐
Name or physician or other health care provider:

Date Administrator Notified

Form Preparer's Name, Title and Phone

Date Prepared