INJURED EMPLOYEE'S INCIDENT REPORT FORM

Print Employee's Name_____ Today's Date_____

SS#_____ Phone where you can be reached_____

Employer_____ Supervisor_____
(manager, head custodian ,principal, etc.,)

INCIDENT INFORMATION

Date of Injury_____ Time_____am/pm Date Reported_____

To Whom Reported?_____ Did you miss time from work for the injury? Yes/No

If yes, give dates and times_____

Returned to work? Yes/No Full Duty / Light Duty ***If No***, date expect to return_____

What part of your body was injured? *(i.e. right leg, left arm)*_____

What is the nature of your injury? *(i.e. cut, sprain, bruise)*_____

Explain in detail how the injury occurred? _____

_____

_____

Where did the injury occur? *(physical location)*_____

Any witnesses? Yes / No ***If yes***, give names_____

Did you seek medical treatment? Yes / No ***If yes***, give date and time_____

Physician's name_____ Return visit date_____

What type of treatment are you receiving?_____

What is the medical prognosis now?_____

Have you injured this part of your body before? Yes / No ***If yes,*** explain when, how and to what extent:_____

How would you prevent a similar accident?_____

_____

Signature of Employee_____ Date_____

SUPERVISOR'S
ACCIDENT INVESTIGATION REPORT

School District_____ Date and time of accident_____

Employee_____ Nature of Injury/Illness_____

ACCIDENT FACTORS

What happened?_____

ACCIDENT TYPE

(Check one)

- ☐ Fall-same level
- ☐ Fall-different level
- ☐ Caught in, on, between
- ☐ Struck by
- ☐ Struck against
- ☐ Over exerted
- ☐ Lifting, moving
- ☐ Pushing/Pulling
- ☐ Twisted
- ☐ Cut/puncture
- ☐ Burned
- ☐ Trip/slip
- ☐ Other_____

ACCIDENT CAUSES

What specific act was responsible for this accident?_____

What specific condition was responsible for this accident?_____

Reasons why the unsafe act was committed and/or why did the unsafe condition existed?

- ☐ Lack of knowledge/experience
- ☐ Defective equipment
- ☐ Adverse weather
- ☐ Failure of use proper personal protection equipment
- ☐ Improper lifting/carry
- ☐ Housekeeping conditions
- ☐ Other_____

CORRECTIVE ACTION

What do you suggest to prevent any similar accidents?

☐ Instructional Training ☐ Repair ☐ Eliminate ☐ Motivation ☐ Proper Placement

Other comments:_____

Signature of Principal or Supervisor_____ **Date**_____

Mail original of this form and First Report of Injury to:
Sedgwick CMS - Omaha
P.O. Box 14513
Lexington, KY 40512-4513

Retain copy for your files

Nebraska Workers' Compensation Court

NWCC Form 1
Revised 11/2006

First Report of Alleged Occupational Injury or Illness

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 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; 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

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.

EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

NOTICE TO EMPLOYER: GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

A: RIGHTS OF THE EMPLOYEE

Under the Nebraska workers' compensation laws, you may have the right to choose a doctor to treat you for your work related injury. You may choose a doctor who has treated you or an immediate family member before this injury happened. Immediate family members are your spouse, children, parents, stepchildren and stepparents. The doctor you choose must have records to show that past treatment was provided. Your employer may ask the person who was treated to give permission so the doctor can verify past treatment.

If you want to choose your doctor, you must tell your employer the name of the doctor you choose. Do this as soon as possible after your employer gives you this notice and before getting any treatment unless it is emergency medical treatment. Once you tell your employer the name of the doctor, you may not change your choice unless your employer agrees or the Nebraska Workers' Compensation Court orders a change.

If you do not choose your doctor, your employer has the right to choose the doctor to treat you. The employer may also choose the doctor to treat you if you or your family member does not give permission so your employer can verify past treatment by the doctor you chose.

You may choose a doctor if your claim is denied. You may also choose the doctor to do major surgery or for an amputation.

You may use part B below to tell your employer the name of the doctor you choose.

B: CHOICE OF DOCTOR

☐ I choose the following doctor to treat me for this work related injury. I certify that this doctor has treated me or an immediate family member before the work related injury.

☐ I do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

DOCTOR'S NAME _____ *SIGNATURE OF EMPLOYEE* _____

DOCTOR'S ADDRESS _____ *DATE* _____

C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work related injury. I certify the doctor named below has treated me or an immediate family member before this work related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

DOCTOR'S NAME _____ *SIGNATURE OF EMPLOYEE* _____ *DATE* _____

DOCTOR'S ADDRESS _____ *SIGNATURE OF EMPLOYER* _____ *DATE* _____