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 ☐ *Emergency Room* ☐ *Future major medical/lost time* ☐
First aid by employer ☐ *Hospitalized overnight* ☐
Minor clinic/hospital ☐ *Hospitalized > 24 hours* ☐

Name of physician or other health care provider:

Date Administrator Notified | Form Preparer's Name, Title and Phone | Date Prepared

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

PART A: NOTICE REGARDING CHOICE OR CHANGE OF DOCTOR

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.

☐ My employer has informed me of the above information regarding choice or change of doctor.

_____
[PRINT NAME OF EMPLOYEE]

_____ _____
[SIGNATURE OF EMPLOYEE] [DATE]

PART 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]

PART 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 OF SIGNATURE]

_____ _____
[DOCTOR'S ADDRESS] [SIGNATURE OF EMPLOYER & DATE OF SIGNATURE]

FORMA DE SELECCION O CAMBIO DE DOCTOR POR EL EMPLEADO

AVISO AL PATRON:

DE ESTA FORMA AL TRABAJADOR LESIONADO, TAN PRONTO COMO SEA POSIBLE DESPUES DE CADA LESION

PARTE A: NOTIFICACION CONCERNIENTE A LA ESCOGENCIA O CAMBIO DE MEDICO

Bajo la Ley de Compensación de Trabajadores en Nebraska, usted puede tener el derecho de escoger al doctor que lo trate para su lesión del trabajo. Usted puede escoger a un doctor que lo haya tratado a usted o a un miembro de su familia inmediata antes de que esta lesión haya ocurrido. Los miembros inmediatos de su familia son su esposa, sus hijos padres, hijastros y padrastros. El doctor que usted escoja debe tener archivos mostrando que tratamiento se le ha dado. Su patrón puede pedir a la persona tratada que de permiso al doctor para verificar el tratamiento pasado.

Si usted quiere escoger doctor, usted debe decir a su patrón el nombre del doctor que elija. Haga esto tan pronto como sea posible, después de que su patrón le haya dado este aviso y antes de recibir tratamiento, a menos que este tratamiento médico en emergencia. Una vez que le diga a su patrón el nombre del doctor, no podrá cambiarlo a menos que su patrón acepte o si la Corte de Compensación a Trabajadores en Nebraska ordena el cambio.

Si usted no escoje doctor, su patrón tendrá el derecho de elegir al doctor que lo trate a usted. El patrón también puede elegir el doctor que lo trate, si usted o el miembro de su familia no da permiso para que su patrón pueda verificar el tratamiento pasado por el doctor escogido por usted.

Usted puede escoger un doctor si su reclamación es negada. Usted tambien puede escoger el doctor para hacer cirujía mayor o amputación.

Usted puede usar la parte B (abajo) para decir a su patrón el nombre del doctor que ha escojido.

☐ Mi empleador me ha informado acerca de la informacion mecionada arriba, concerniente a la escogencia o cambio de medico.

_____
[IMPRIMIR EL NOMBRE DEL EMPLEADO]

_____ _____
[FIRMA DEL EMPLEADO] [FECHA]

PARTE B: SELECCION DE DOCTOR

☐ Yo escojo al doctor mencionado a continuación para que me trate por esta lesión del trabajo. Yo certifico que este doctor me ha tratado o ha tratado a miembros de mi familia antes de esta lesión del trabajo.

☐ Yo no tengo o no quiero escoger a un doctor que me haya tratado a mi o a miembros de mi familia inmediata.

_____ _____
[NOMBRE DEL DOCTOR] [FIRMA DEL EMPLEADO]

_____ _____
[DOMICILIO DEL DOCTOR] [FECHA]

PARTE C: USE PARA CAMBIAR LA SELECCION HECHA EN LA PARTE B, ARRIBA

Yo quiero cambiar mi selección de doctor o yo quiero escoger a un doctor que me trate para mi lesión relacionada con el trabajo. Yo certifico que el doctor mencionado abajo, me ha tratado o ha tratado a miembros de mi inmediata familia antes de esta lesión en el trabajo. Yo entiendo que yo no puedo hacer este cambio a menos que mi patrón esté de acuerdo o a menos que la Corte de Compensación de Trabajadores en Nebraska ordene el cambio.

_____ _____
[NOMBRE DEL DOCTOR] [FIRMA DEL EMPLEADO Y FECHA DE LA FIRMA]

_____ _____
[DOMICILIO DEL DOCTOR] [FIRMA DEL PATRON Y FECHA DE LA FIRMA]