

RULE 29

FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY OR ILLNESS

- A.** In every case of reportable injury arising out of and in the course of employment, whether resulting from accident or from diagnosed occupational disease, the employer or its insurer or risk management pool shall file a report thereof with the compensation court, specifically stating the nature and extent of the injury. Such first report of alleged occupational injury or illness shall be filed within 10 days after the employer or insurer or risk management pool has been given notice or has knowledge of such injury.
- B.** Except as otherwise approved by the administrator of the compensation court, all first reports of alleged occupational injury or illness shall be filed electronically in the form and manner and to include the content prescribed by the administrator. With approval of the administrator, such reports may be filed by means of the paper First Report of Alleged Occupational Injury or Illness (Form 1), an exact copy of which appears on the two pages following this rule. The mandatory fields identified on the back of the Form 1 must be completed before the report will be deemed filed with the court. Blank forms for paper reports are furnished by the administrator upon request.
- C.** No report of alleged occupational injury or illness shall be deemed filed with the court until the report has been received and accepted by the court.

Sections 48-144, 48-144.01, 48-163, 48-165, R.S. Supp., 2005.
Effective date November 16, 2006.

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 _____					
Policy Number _____				Self Insured <input type="checkbox"/>		Claim Administrator Claim # _____			
Policy Period: From _____ To _____				<i>Check if Appropriate</i>		Jurisdiction Claim # _____			
Insurance Carrier/Self-Insured Code # _____				Insured Report # _____			Jurisdiction _____		
Employee									
Name <i>(Last, First, Middle)</i> _____				Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Days Worked Per Week _____		Sex Male <input type="checkbox"/>	
Address _____				Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>				Female <input type="checkbox"/>	
City _____				Number of Dependents _____		Occupational Job Title _____			
State _____				Marital Status		Wage \$ _____		Occupational Code _____	
Zip Code _____				Married <input type="checkbox"/>		Hourly <input type="checkbox"/>		NCCI Class Code _____	
Phone _____				Separated <input type="checkbox"/>		Daily <input type="checkbox"/>		Date Employee Began _____	
Date of Birth _____				Unmarried <input type="checkbox"/>		Weekly <input type="checkbox"/>		Work-Related Duties _____	
Social Security Number _____		Date Hired _____		Unknown <input type="checkbox"/>		Bi-Weekly <input type="checkbox"/>		Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <input type="checkbox"/>	
						Monthly <input type="checkbox"/>			
Occurrence/Treatment									
Date of Injury/Illness _____			Time Employee Began Work AM <input type="checkbox"/> PM <input type="checkbox"/>			Time of Occurrence AM <input type="checkbox"/> PM <input type="checkbox"/>		Last Work Date _____	
						(Cannot be determined <input type="checkbox"/>			
Where Did Injury/Illness Occur? County _____ State _____ Zip _____				Did Injury/Illness Occur On Employer's Premises? 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"/> First aid by employer <input type="checkbox"/> Minor clinic/hospital <input type="checkbox"/>				Emergency Room <input type="checkbox"/> Hospitalized overnight <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/>		Future major medical/lost time <input type="checkbox"/>		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.