NWCC Form 1
Revised 12/2011

# Nebraska Workers' Compensation Court
# First Report of Alleged Occupational Injury or Illness

**Please forward completed form to Personnel when completed (humanresources@sarpy.com)**

Reset

## Employer

Employer FEIN 47-6007504 SIC Code _____ Report Purpose _____ OSHA Log Case # _____

Employer Name(s) Sarpy County

Address 1210 Golden Gate Drive

City Papillion

State NE Zip Code 68046 Phone 402-593-2349

Insured Name *(If different from employer name)*

Insured Address *(If different)*

Location _____

## Insurance Carrier

Carrier FEIN 47-0720390

Administrator FEIN 20-0469227

Name NIRMA II

Address PO Box 80498

City Lincoln

State NE Zip Code 68501-0498 Phone 1-800-424-7076

Policy Number County Government Pool

Policy Period: From _____ To _____

Insurance Carrier/Self-Insured Code # _____

Claim Administrator *(Name, address & phone number)*

NIRMA, Inc
PO Box 80498
Lincoln, NE 68501-0498 1-800-424-7076

Self Insured ☐ *Check if Appropriate*

Claim Administrator Claim # _____

Jurisdiction Claim # _____

Insured Report # _____ Jurisdiction NE

## 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*
*First aid by employer* ☐ *Hospitalized overnight* ☐ *medical/lost*
*Minor clinic/hospital* ☐ *Hospitalized > 24 hours* ☐ *time* ☐

*Name of physician or other health care provider:*

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