Nebraska

Nebraska Workers' Compensation Court

First Report of Alleged Occupational Injury or Illness

NWCC Form 1
Revised 12/2011

Employer

Employer FEIN 47-0561185 SIC Code 5014 Report Purpose ____ OSHA Log Case # ____

Employer Name(s) Nebraskaland Tire
Address 2904 S Spruce
City Wichita
State KS Zip Code 67216 Phone 316 522 5114

Insured Name *(If different from employer name)*
Insured Address *(If different)*
Location *

Insurance Carrier

Carrier FEIN ☐ Mutual - 41-0417460 ☒ Service - 41-0984698
Name ☐ Federated Mutual Insurance Company ☒ Federated Service Insurance Company
Address PO Box 486
City Owatonna
State MN Zip Code 55060-0486 Phone (800) 533-0472 Fax 866-636-8660
Policy Number 339-495-4
Policy Period: From 4/2013 To 4/2014
Insurance Carrier/Self-Insured Code # ____

Administrator FEIN ____
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