Corn Belt League
INCIDENT/PROTEST REPORT FORM

Mail to:
Corn Belt Collegiate Summer League
Attn: Joe Siwa
2900 S. 110th St
Omaha, NE 68144
Fax to: (402) 399-2019

Date of Report:_____
Date of Incident:_____

NAME_____
(name of person filing report)

ADDRESS_____ CITY_____ STATE_____ ZIP_____

PHONE_____

DESCRIPTION OF INCIDENT
Date_____
Location_____
Description_____
_____
_____
_____
_____
_____

Witness: NAME_____
ADDRESS_____ PHONE_____

Witness: NAME_____
ADDRESS_____ PHONE_____

FOLLOW-UP

NAME_____ DATE_____

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 _____

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 ☐

Date of Birth	Social Security Number	Date Hired

Occurrence/Treatment

Date of Injury/Illness	Time Employee Began Work	Time of Occurrence	Last Work Date
	AM ☐ PM ☐	(Cannot be determined ☐) AM ☐ PM ☐	

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

Underlined items are mandatory fields. A first report of injury or illness submitted without this information will be returned unfiled.

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 workers' compensation insurer, approved self insured, or intergovernmental risk management pool.
- Address — address, city, state and zip code of insurer.
- Phone — phone number of insurer.
- ClaimAdministrator (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.
- Social Security Number. The social security number must be provided. This is mandatory pursuant to Neb.Rev.Stat. §48-144, Rule 29 of the Workers' Compensation Court Rules of Procedure, and Section 7(a)(2)(B) of the Privacy Act of 1974. The social security number is used by the Nebraska Workers' Compensation Court for purposes of verifying the identity of the employee and administering the Nebraska Workers' Compensation Act. It is a unique identifier and is needed because of the number of persons who have similar names and birth dates, and whose identities can only be distinguished by social security number. The social security number may also be shared with claims handling entities for purposes of processing a claim for workers' compensation benefits and verifying the identity of the claimant.
- Date of Birth — the date the injured worker was born.
- 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.