

REPORT of ALLEGED ON THE JOB INJURY or ILLNESS
Information to be used to electronically file with the Nebraska Workers' Compensation Court
Employer

City of Lincoln Risk Management Division
555 S. 10th Street, Suite 302
Lincoln, NE 68508
402-441-7671
Fax 402-441-6800
Risk Management Claim Number _____

FEIN 47-6006256 City of Lincoln
FEIN 47-0803080 Lincoln Electric System
FEIN 47-0825472 Community Health Endowment
UI# 0160266007
SIC Code #91313
Insurance Carrier/Self-Insured Code # SI-043

Employee Information

Name (Last, First, Middle) _____
Home Address _____
City _____ State _____ Zip Code _____
Phone No. (402)- _____ Social Security Number _____ - _____ - _____
Date of Birth: ____/____/____ Date Hired: ____/____/____
Sex: Male Female
Marital Status: Married Separated Unmarried Unknown
Number of Dependents _____

Department: _____ Division _____ Phone Number _____
Wages \$ _____ Hourly or Weekly \$ _____ TTD Rate \$ _____
Employment Status: Full Time Part Time Other _____
Date Employee Began Work-Related Duties ____/____/____
Occupational Job Title _____ Occupational Code _____
Full Pay for Date of Injury Yes No
Salary Continued: Yes No
Number of Hours Worked Per Day _____ Number of Days Worked Per Week _____

Injury Information and Treatment

Date of Injury/Illness ____/____/____ Time of Injury/Illness _____ AM PM Cannot be determined
Time Employee Began Work _____ AM PM Last Work Day ____/____/____
Where Did Injury/Illness Occur?
Address: _____, City: _____ Zip Code: _____
Did Injury/Illness Occur on Employer's Premises? Yes No
Date Employer Notified ____/____/____ Date Disability Began ____/____/____
Date Returned to Work ____/____/____ If Fatal, Date of Death ____/____/____

Type of Injury or Illness (Briefly describe the nature of the injury, e.g. Laceration to forearm, Left or Right)

Part of Body Affected (indicate the part of the body affected by the injury or illness; e.g. right forearm, lower back; and how it was affected)

How Injury or Illness Occurred (Describe activity and tools, materials, equipment the employee was using; how injury occurred)

Initial Treatment: No Medical treatment First Aid by employer Minor Clinic/Hospital Emergency Room
Hospitalization overnight Hospitalized > 24 hours Future major medical/Lost Time

Form Prepared By: Name, Title, and Phone Number _____

Date Administrator Notified: ____/____/____



City of Lincoln Employee Injury or Illness Report

If more than a record-only incident, complete 'Report of Alleged Occupational Injury & Illness' form and forward completed documents to Risk Management within one business day.

To be completed by the Injured Employee or their Supervisor (if employee physically unable).

Date of Injury/Illness ____ / ____ / ____ Month Day Year	Time Employee Began Work ____ <input type="radio"/> A.M. <input type="radio"/> P.M.	Time Injury/Illness Occurred ____ <input type="radio"/> A.M. <input type="radio"/> P.M.	Date Employer Notified ____ / ____ / ____ Month Day Year
Where did Injury/Illness Occur? Address: _____			
Did injury/illness occur on City property? <input type="radio"/> YES <input type="radio"/> NO			
Were there any witnesses to injury/illness? <input type="radio"/> YES <input type="radio"/> NO <i>If yes, list names, addresses, phone numbers</i> _____			
Briefly describe the nature of the injury; eg. Laceration to the forearm _____			
Indicate the part of the body affected by the injury; eg. Right forearm/lower back _____			
How did the injury occur? (Describe the sequence of events and include any objects or substances that directly injured the body) _____ _____ _____			
Initial Treatment: <input type="checkbox"/> No Medical Treatment <input type="checkbox"/> First Aid by Employee <input type="checkbox"/> Minor Clinic Hospital <input type="checkbox"/> Emergency Care			
Is this claim for record only? <input type="checkbox"/> YES <input type="checkbox"/> NO			

A: RIGHTS OF THE EMPLOYEE

Under the Nebraska Worker's 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. Use Part B below to tell your employer the name of the doctor you choose.

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 choose a contracted medical provider (Company Care or Linc Care).

I do not have or I do not wish to choose a doctor who has treated me or an immediate family member; therefore my employer may choose a doctor.

DOCTOR'S NAME

DOCTOR'S ADDRESS (If other than Company Care or Linc Care)

EMPLOYEE SIGNATURE

DATE

IMMEDIATE SUPERVISOR SIGNATURE

DATE