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" and 'Choice/Change of Doctor' forms. Forward completed documents to Risk Management within one business day.

EMPLOYEE INFORMATION

Employee's Name _____ Home Phone _____

Home Address _____ Employment Classification _____

DETAILS OF ACCIDENT/INJURY/ILLNESS

Day and date of Injury _____ Time of Injury _____ AM / PM

When was injury reported to supervisor? Date _____ Time _____ AM / PM

Address and specific location where injury/illness occurred _____

Describe accident *(be specific)* _____

Nature and extent of injury *(EXTENT: superficial, minor, serious; TYPE: burn, laceration, sprain, fracture; BODY PART: left hand, right foot, lower back)*

Cause of accident: Describe any unsafe act, omission or condition (be specific) _____

Witnesses *(names, addresses, phone numbers)* _____

_____

What action can be taken to prevent similar accidents? _____

_____

What first aid was administered? _____

Was doctor seen? ☐ Yes ☐ No Date seen _____ If no, is this report for record only? ☐ Yes ☐ No

Doctor's Name _____ Phone _____

Address _____

Name of Hospital/Clinic _____ Phone _____

Address _____

REPORTING AGENCY

☐ Police ☐ Fire/Rescue ☐ Other Agency _____

Date Reported _____ Case # _____ Investigating Officer _____

PREPARED BY:

Department/Division/Section _____ Date Prepared: _____

Employee _____ Phone _____

Supervisor _____ Phone _____

Risk Management, 555 S. 10th St., Suite 302, Lincoln, NE 68508
Phone 402-441-7671, FAX 402-441-6800

EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

CITY OF LINCOLN: GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

A: RIGHTS OF THE EMPLOYEE

Under the Nebraska workers' 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.

You may use the 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.

DOCTOR'S NAME

EMPLOYEE'S NAME

DOCTOR'S ADDRESS

EMPLOYEE HOME ADDRESS

DATE