

First Report of Alleged Occupational Injury or Illness

Employer

Employer FEIN <u>47-6006427</u> SIC Code: _____ Report Purpose _____ OSHA Log Case # _____	
Business Name(s) <u>ADAMS COUNTY</u> Address <u>500 WEST 4TH</u> City,State,Zip Code: <u>HASTINGS, NE 68901</u> Phone: <u>(402) 461-7107</u>	Insured Name (if different from Employer Name): <u>ADAMS COUNTY</u> Employer's Location Address (if different)

Insurance Carrier

Carrier FEIN: <u>47-0720390</u>	Admin FEIN: <u>20-0469227</u>	
Name: <u>NIRMA II</u>	Claim Administrator (Name, Address, & Phone Number)	
Address: <u>P.O. Box 80498</u>	NRMA, Inc P O Box 80498 Lincoln, NE 68501-0498 1-800-424-7076	
City: <u>Lincoln</u>	Check if Appropriate Self Insured <u>9</u>	
State: <u>NE</u> Zip Code: <u>68501-0498</u> Phone: <u>1-800-424-7076</u>		Carrier / Claim Administrator Claim # _____ Jurisdiction Claim # _____
Policy Number: <u>County Government Pool</u>	Insured Report # _____	Jurisdiction <u>NE</u>
Policy Period: From <u>7/1/2010</u> To <u>6/30/2011</u>	Insurance Carrier / Self-Insured Code # _____	

Employee

Name (Last, First, Middle) _____ Address _____ City _____ State _____ Zip Code _____ Home Phone _____ Work Phone _____ Cell Phone _____ Date of Birth: _____ SS #: _____ Date of Hire: _____	Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/> Salary Cont. Yes <input type="checkbox"/> No <input type="checkbox"/>	Number of Days worked per Week <u> </u> Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
	Number of Dependents <u> </u> Marital Status Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown <input type="checkbox"/>	Wage \$ _____ Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>

Occurrence / Treatment

Date of Injury / Illness	Time Employee Began Work _____ AM <input type="checkbox"/> _____ PM <input type="checkbox"/>	Time of Occurrence _____ AM <input type="checkbox"/> (Cannot be determined <input type="checkbox"/>) PM <input type="checkbox"/>	Last Work Date
Where Did Injury / Illness Occur? County _____ State _____ Zip _____		Did Injury / Illness Occur On Employer's Premises? Yes <input type="checkbox"/> No <input type="checkbox"/>	
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. Laceration 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, lower back)	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 <input type="checkbox"/> First aid by employer <input type="checkbox"/> Minor clinic / hospital <input type="checkbox"/>	Emergency Room <input type="checkbox"/> Hospitalized Overnight <input type="checkbox"/> Hospitalized > 24 hours <input type="checkbox"/>	Future major medical / lost time <input type="checkbox"/>	Name of physician or other Health Care Provider:
Date Administrator Notified	Form Preparer's Name, Title and Phone		Date Prepared	

