



# Workers' Compensation Policy/Procedure Guide for State of Nebraska Agencies

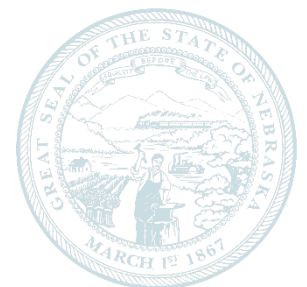
The workers' compensation program for State of Nebraska employees is administered by the Department of Administrative Services, Risk Management Division.

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Purpose:

The purpose of this publication is to provide Nebraska State Agencies with general information about workers' compensation and the State's workers' compensation program. The workers' compensation program for State of Nebraska employees is administered by the Department of Administrative Services, Risk Management Division ("Risk Management"). Risk Management contracts with Gallagher Bassett Services, Inc. ("Gallagher") to provide third-party administration services, i.e. assistance with the administration of the workers' compensation program.

This publication also outlines the required processes and forms that must be completed by each State Agency. Some Agencies, however, may require the completion of additional forms or practices. This publication does not seek to replace or change those additional policies, but to establish a unified practice for the filing of claims and submission of required documentation.

Not all questions will be answered, nor will all provisions of law be covered, please direct questions to Risk Management.

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What is Workers' Compensation:

Workers' Compensation provides benefits to employees who sustain an injury or occupational disease arising out of and in the course of their employment and who are not willfully negligent at the time of the injury.

The State's workers' compensation program is governed by the Nebraska Workers' Compensation Act, *Neb. Rev. Stat.* § 48-101 - § 48-1,118. Workers' Compensation is the exclusive remedy for an injured employee. As a result, for the right to receive workers' compensation benefits from the employer, an employee forfeits his or her right to file a civil action against the employer for damages for work-related injuries or illnesses. The State of Nebraska is self-insured and makes all payments from the workers' compensation revolving fund.

Once an occupational injury or illness is determined to be compensable, the amount of workers' compensation benefits are calculated and benefits begin to be paid. Workers' compensation benefits include all authorized medical and hospital expenses, partial replacement of income (if an employee is temporarily disabled), vocational rehabilitation assistance, permanent disability payments, and/or death benefits for financial dependents (if the injury results in death).

Explanation of Benefits:

- Medical Treatment: The employer is liable for all reasonable medical and hospital services, appliances, prescribed drugs, prosthetic devices, and other supplies that are necessary as the result of a work-related injury. Expenses for medical travel may be paid in some instances. If an employee unreasonably refuses medical treatment, compensation may be reduced, limited, or suspended.
- Temporary Total Disability (TTD): Money paid to an employee who is temporarily unable to work because of a work-related injury or illness. TTD is paid until the employee's

medical condition is resolved or is determined to be at maximum medical improvement. The employee CANNOT be working to receive this benefit.

TTD does not begin until an employee has reached the "7 Day Wait Period." If an employee is unable to work for 7 days after the work-related injury, TTD benefits will begin on the 8<sup>th</sup> day. When an employee is unable to work due to a work-related injury or illness, the employee is considered to be disabled. Compensation for the first seven days of disability is not paid unless the employee's disability last six weeks or more. The first day of disability is included in the seven-day waiting period and a partial day of disability is considered a full calendar day for purposes of the waiting period. The days of disability do not need to be consecutive.

TTD benefits are paid at 66 2/3% of the employee's average weekly wage. The average weekly wages are based upon the wages the employee received 26 weeks prior to the date of injury. Overtime is included, however, it will be paid as straight time. For seasonal employees, the average weekly wage considers the 50 weeks of wages prior to injury.

- Temporary Partial Disability (TPD): Money paid to an employee who misses partial hours from work due to attending medical appointments and/or works partial hours due to a medical restriction connected to the work-related injury or illness. This benefit pays 2/3 of the shortage in earnings and is based upon the gross earnings for the pay period. However, if an employee loses time from work, but still earns his or her average weekly wage, TPD benefits are not due to the employee.
- Permanent Partial Disability (PPD): Once an employee has reached maximum medical improvement, a permanent disability rating may be received if there is any remaining disability/functional deficit with the injured body part that reduces the employee's ability to compete in the open labor market. The disability rating will determine the amount of monetary compensation. Nebraska law has a scheduled members chart that assigns a certain monetary figure for each body part.

PPD can be collected while an employee is working and does not require the employee to meet the 7-day waiting period for the benefit to begin. PPD is paid at the rate of 2/3 of the employee's average weekly wage, subject to the maximum and minimum benefit rates, times the number of weeks of compensation set out in the statutory schedule for the body part or percentage of loss thereof.

- Loss of Earning Capacity (LOE): A loss of earning capacity evaluation is completed when an employee suffers an injury to the head, spine, or bilateral body parts. Injuries to these body parts are often referred to as Body as a Whole (BAW). If an employee sustains a body as a whole injury, and is assigned an impairment rating, permanency benefits are only considered when permanent restrictions are assigned. An employee can be assigned an impairment rating for a body as a whole injury, but if there are no permanent restrictions, there is no impairment.
- Vocational Rehabilitation (VR): When an employee is unable to return to regular job duties as a result of the work-related injury, a Vocational Rehabilitation Counselor may be assigned to the employee. These services are voluntary and, if not offered by the employer, the employee can request vocational rehabilitation services. The Counselor will assist the employee with possible work modification or a formal training program and placement assistance into a new, more appropriate line of work. This is known as a

vocational plan. At times, a vocational plan may include assisting the employee with obtaining an Associate's Degree. Regardless of the plan, it must be approved by the Nebraska Workers' Compensation Court.

- Death Benefits: If an injury results in the death of an employee, the widow/widower is paid death benefits for his or her life or until remarriage. Upon remarriage, the widow/widower receives two years of benefits in a lump sum. Benefits are calculated at 66 2/3 percent of the employee's average weekly wage at the time of the injury, if there are no children, and at 75% if there are children, subject to the maximum and minimum benefits per week. Children are entitled to a percentage of the death benefit until they reach the age of 19 or 25 if enrolled full-time at an accredited educational institution, or until the end of actual dependency. Additionally, burial expenses up to a maximum of \$6,000.00 are paid.

### Types of Workers' Compensation Claims:

Workers' compensation claims are classified as: Report Only, Medical Only, and Indemnity.

- Report Only: An example of a Report Only claim is when an employee is injured during the course and scope of employment but does not seek medical attention.
- Medical Only: Medical Only claims involve medical payments for treatment rendered when the employee has NOT lost more than seven calendar days from work as a result of the injury or illness, and is NOT receiving any other workers' compensation benefits.
- Indemnity: Indemnity claims come into play when an employee has missed more than seven calendar days from work as a result of the occupational injury or illness, and receives benefits to supplement the employee's lost income.


### Additional Considerations:

#### Choice of Doctor (Employee Choice):

Upon suffering a work-related injury or illness, an employee has the right to select a physician. However, the physician selected for treatment must maintain prior medical records of the employee (or an immediate family member). Employees must be informed of the right to choose a physician, and complete the Form 50 upon notifying the employer of a work-related injury.

If the employee does not have or does not choose such a physician, then the employer may select the physician. Gallagher Bassett has a panel of preferred providers. Please see below for more information. Please note, that the employee must still complete the Form 50 and indicate that no particular physician has been selected.

The initial choice of physician when chosen by the employee or employer can only be changed when both the employee and the employer agree on the change or the Nebraska Workers' Compensation Court orders the change. An employee is not entitled to a second opinion, but the employer may agree to the arrangement. If the employer does not give proper notice to the



employee regarding the right of selection, then the restrictions on changing physicians do not apply and the employee has the right to select any physician.

The employee may also select a physician to perform a major surgical operation or in cases involving dismemberment. Physician means any person licensed to practice medicine and surgery, osteopathic medicine, chiropractic, podiatry, or dentistry in the State of Nebraska or in the state in which the physician is practicing. However, an employer may request that the employee submit to a medical examination by a doctor of its choice at the company's expense.

In the case of the State of Nebraska's program, Agency HR is responsible for notifying the employee of the right to choose a physician and verifying that the Form 50 is completed. Only Risk Management or Gallagher Bassett may negotiate change of physicians, second opinions, or submission to medical examinations.

Preferred Provider Panel Access:

If an employee does not identify a physician for treatment, Agency HR should access Gallagher Bassett's preferred provider panel to find a physician at the web address listed below.

[www.talispoint.com/gb/gbcare1](http://www.talispoint.com/gb/gbcare1)

## DIVISION OF RESPONSIBILITIES WITHIN THE WORKERS' COMPENSATION PROGRAM

### Risk Management

1526 K Street, Suite 180, Lincoln, NE 68508  
402.471.2551 (Office)  
402.471.2800 (Fax)  
as.riskmanagement@nebraska.gov

The State of Nebraska's workers' compensation program is administered by the Risk Management Division of the Department of Administrative Services.

- Coordinates State of Nebraska's workers' compensation program activities.
- Counsels agency representatives and employees regarding workers' compensation principles, practices, and procedures.
- Ensures that an employee receives legally mandated workers' compensation notices.
- Provides training to agencies on ways to reduce workers' compensation costs.
- Implements loss prevention and loss control programs.
- Determines workers' compensation assessment rates based on agencies loss experiences.
- Advises department representatives on reasonable accommodation and return to work procedures.
- Coordinates and assists agencies with health and safety programs.

### Gallagher Bassett Third Party Administrator

#### Physical Address:

10050 Regency Circle, Suite 300  
Omaha, NE 68114  
402.972.4780 (Office)  
402.972.4777 (Fax)

#### Send Medical Bills/Medical Reports:

Gallagher Bassett Services, Inc.  
PO BOX 2381  
Clinton, IA 52733-2831  
866.324.5585 (Office)

Gallagher Bassett was hired by the State of Nebraska to assist with the administration of the State's workers' compensation program.

- Determines the validity of occupational injury or illness claims.
- Determines eligibility for workers' compensation benefits.
- Assists employee with managing medical care and facilitates return to work.
- Processes and pays medical bills for accepted claims.
- Calculates and issues payments for lost wages.

### State Agencies/Boards/Commissions State of Nebraska

- Assists employees with completion of the First Report of Injury Form and all other required forms.
- Submits claims via Risx-Facs or call 1-844-4GB-RED1, in emergencies.
- Processes sick and vacation leave to supplement workers' compensation benefits and regular payroll benefits, if owed.
- Provides employees with access to reasonable accommodations and return to work options.
- Strives to maintain a safe environment in all areas of agency operations.
- Responds and corrects hazardous conditions.

## WHEN AN INJURY OCCURS:

Prompt medical care is essential to a quick recovery. Quality medical care and medical follow-up can often mean the difference between complete recovery from an injury/illness or lasting physical disability. If an employee is injured at work, they should receive medical care immediately.

### Reporting Injury/Completion of Forms:

When an injury occurs, it should be reported immediately to the employee's supervisor or Agency HR. The injured employee must complete the following forms and turn them in to Agency HR:

- Employee Incident Form;
- Authorization for Release of Information (HIPAA Compliant); and
- Employee's Choice or Change of Doctor Form (Form 50).

Supervisors shall complete and submit to agency human resources representative:

- Supervisor Investigation Report and
- Witness Form (Supervisor should have all individuals that witnessed the injury complete this form.)

### Directives to the Injured Employee:

#### Medical Treatment Needed:

Agency HR should provide the injured employee with the following forms and information:

- 7 Day Wait Period; Acknowledgment Form;
- Request to Supplement Workers' Compensation Benefits Form;
- Report of Work Ability;
- First Script Pharmacy Card;
- Mileage Reimbursement Form;
- and
- Pamphlet on GBGO App.

#### Medical Treatment NOT Needed:

Agency HR should provide the injured employee with the following forms and information:

- 7 Day Wait Period Acknowledgment Form;
- Request to Supplement Workers' Compensation Benefits Form; and
- Pamphlet on GBGO App.

Injured employees may be entitled to supplement workers' compensation benefits with injury leave or accrued sick, vacation or comp time. However, benefits should never be supplemented without the employee's formal approval. The 7-Day Wait Period Acknowledgment Form and Request to Supplement Workers' Compensation Forms have been created to ensure that employees are informed of the opportunity and potential consequences for supplementing benefits.



The Report of Work Ability must be given to the injured employee to be completed by the physician that treats the employee after a work-related injury/illness. This form must be submitted to Agency HR prior to the employee returning to work. The purpose of this form is to confirm that the employee is fit for duty and/or to support the employee with any modified duty restrictions. An employee should never return to work without an updated work ability form on file. Please note, that an updated Report of Work Ability is needed each and every time after an employee visits the physician regarding the work-related injury/illness.

Prior to an employee visiting a physician regarding a work-related injury/illness, Agency HR should provide the employee with a First Script Pharmacy Card. Agency HR should complete the card. The incident number (generated after the claim is filed) should be written in the Member ID slot. This card will allow the employee to receive the first set of prescriptions without charge. This is important because the workers' compensation claim has not yet been determined for compensability. If the claim is accepted, the employee will be mailed a prescription card to use going forward for treatment of the work-related injury or illness. The First Script Pharmacy card may only be used once, and an employee should never be given additional cards.

Employees should be made aware of Gallagher Bassett's mobile app for injured workers. The app is called GBGO. GBGO helps employees manage their lost time claims anytime, anywhere from their Apple or Android smartphones. Capabilities include:

- View claim summary.
- View benefits payment history.
- Receive details on status of benefit checks.
- Call or email their GB Resolution Manager with one click.
- Access Pharmacy Card.
- View other payment types (travel expense, etc.).

### Filing Claim:

After an employee has completed the necessary forms, Agency HR must file the documentation with Gallagher Bassett. Claims may be filed online at [www.risxfacs.com](http://www.risxfacs.com). Each agency has pre-identified individuals responsible for handling this task and have been provided login information. If an agency needs login credentials, please contact Risk Management. In cases of emergency or when there is no internet access, claims may be filed by calling 1-844-4GB-RED1.

Once the claim has been filed/submitted, a First Report of Injury (FROI) Form will be generated and emailed to Agency HR. A copy of the FROI should be kept in the employee's agency workers' compensation file. Gallagher Bassett will then open a file for the employee and begin investigation. A workers' compensation claim will be accepted or denied within three (3) business days, on average.

A Resolution Manager (a.k.a. Adjuster) with Gallagher Bassett will contact the employee within one (1) business day of the reported injury. The Resolution Manager investigates claims by interviewing the injured employee and witnesses to determine the extent of liability. It is important that the employee speak with the Resolution Manager immediately so as not to delay the processing of the claim.

### Next Steps:

After the claim has been filed, Agency HR should complete and submit the following forms to the assigned Resolution Manager on the newly filed workers' compensation claim:

- 26 Week wage Statement.
  - 52 Week Wage Statement is needed for Part-Time or Seasonal Employees.
- Payroll Benefits (PB) Form.
- Employee Incident Form.
- Supervisor Investigation Report.
- Witness Statement(s).

The 26 Week Wage Statement should be submitted to the Resolution Manager within 24 hours of the claim being filed. If an employee works part-time or is seasonal, a 50-week wage statement is needed.

To ensure that employees are paid correctly, it is important that the Payroll Benefits Analysis (PB) Form is completed by Agency HR and submitted to the Resolution Manager. PB Forms should be submitted to the Resolution Manager 2-3 days prior to payroll processing. Agency HR only needs to complete the column titled "hours missed". In this column and for each date of the payroll period, enter in the number of hours the employee missed from work. Be sure to enter in the missed work code as well. The missed work codes are listed at the bottom of the form and include, medical appointments (MA), doctor's note (DN), no light duty available (NLD), day off (DO), paid holiday (HOL), personal illness – not work comp related (PI), and not work comp related (NWC).

The Resolution Manager will then use this form to calculate the amount of workers' compensation benefits owed to the employee for the payroll period. Once calculated, the Resolution Manager will return the form to agency payroll, within 24 hours, with the reported amount of benefits to be paid. Agency payroll may then use that amount to determine how much to supplement an employee's pay. Again, employees must choose to have their workers' compensation benefits supplemented. Any injury leave, sick, vacation and/or comp time used to supplement the benefits, should be written on the PB form and kept in the employee's agency workers' compensation file.

Resolution Manager's will also indicate on the PB Form the dates of the 7-day wait period and when, if ever, the retroactive pay was paid.

After the 7-day wait period is over, an employee may wish to continue supplementing workers' compensation benefits. If so, the employee must complete and return the Request to Supplement Workers' Compensation Benefits form to Agency HR. An employee's benefits should never be supplemented without the employee's approval. Further, an employee may elect at any time to discontinue to supplement benefits.

### Compensability Determination:

Employees are notified via regular mail, or electronic mail, or telephonic notice for claim acceptance or denial.

If the claim is accepted, Gallagher Bassett will work closely with the employee, medical providers, Risk Management, and the employee's Agency HR to get the employee to maximum medical improvement. Gallagher Bassett will also process medical and lost time payments for all approved workers' compensation claims. An injured employee may also be eligible for reasonable mileage

reimbursement for travel to and from medical appointments for treatment of the work injury. For reimbursement, a mileage request form must be submitted to Gallagher Basset.

Pursuant to *Neb. Rev. Stat. §48-119*, injured workers are not entitled to payment during the first 7-days of an injury. This is known as the 7-day wait period. It is important to note, that the 7-day wait period is considered seven (7) instances of absences related to the work injury/illness. It is possible for these absences not to be consecutive and span over a period of time. If an employee continues to be disabled for 6 weeks (after the 7-day wait period has been met), the employee will be paid workers' compensation benefits for the missed time. This is known as Retroactive Pay. Gallagher Bassett will make this payment, not the Agency. However please note, the State of Nebraska allows its employees to use injury leave, sick, vacation, and/or comp time during the 7-day wait period. Most State employees receive 5 instances of injury leave a year. Some employees are entitled to more depending on the agency and job description.

When an employee is injured on the job, injury leave, vacation, sick and/or comp time may be used to supplement the employee's time off during this period. If comp time is used, it should be paid as straight time. However, an Agency MUST get an employee's approval before using these time off benefits. Further, employee's must sign the 7-Day Wait Period Acknowledgment and Agreement form acknowledging that all injury leave (paid during the 7-day wait period) shall be repaid to the Agency should the employee reach the 7-day wait period and is paid retroactive pay. If an employee is paid retroactive pay, the employee must also be credited back any sick, vacation, and/or comp time used.

If an employee does not have injury leave, vacation, sick, and/or comp time available to supplement the lost time, the employee will not be paid for the first 7-days of injury. Should the employee continue to be disabled after 6 weeks, the employee will receive retroactive pay.

#### *Conducting a Safety and Accident Investigation:*

Supervisors are responsible for conducting the initial investigation of accidents. However, Agency HR may also assist with these investigations. Please keep in mind that an agency may have additional procedures for investigating accidents. If so, please follow those procedures in addition to those outlined below. The goal is to gather information about the causal factors to prevent future accidents, not to place blame.

#### Tips on what to do:

1. Care for the injured employee by providing first aid and/or emergency medical care.
2. Do whatever is necessary to prevent the risk of further injuries, accidents, or damages.
3. Conduct interviews with all involved employees or witnesses as soon as possible after the incident occurs, even if it is a near miss.
  - a. The goal of the interview is not to find fault, but to get the facts of what happened.
4. Collect information that will help pinpoint the circumstances of the incident, such as events prior to the incident, logs, written reports, witness statements, physical evidence, sketches, videotapes, or photographs of the accident scene.

5. Preserve and secure any equipment which may have contributed to the injury.
  - a. It may be necessary to have the equipment analyzed and used in a legal action against the manufacturer.
6. Identify contributing factors such as hazardous conditions, unsafe procedures or defective equipment to reduce the risk of additional injuries.
7. Discuss prevention methods and get employees' ideas on how to make the workplace safer.
8. Determine if training or retraining on safety procedures and equipment is necessary.
9. Review all of the information to identify potential hazards and to look for solutions to prevent future injuries or accidents.

### Explanation of Forms:

7-Day Wait Period Acknowledgment and Agreement: The 7-Day Wait Period Acknowledgment and Agreement form should be reviewed and signed by an employee upon reporting a work related injury/illness. This form explains that an employee will be required to re-pay the Agency any injury leave paid on the employee's behalf during the 7-day wait period, if an employee continues to be disabled for at least 6 weeks and receives retroactive workers' compensation benefits.

26 Week Wage Statement: A wage statement outlines the earning for the 26 weeks prior to the injury and is necessary to calculate the correct disability rate. Agency HR should submit this form to Gallagher Bassett within 24 hours of reporting the injury, if not immediately.

Employee Incident Form: The Employee Injury/Illness form should be given to the employee after an injury/illness has occurred. This form documents the employee's account of how the injury/illness happened. The employee should sign and return the form to Agency HR.

First Report of Injury: The First Report of Injury contains information contained within the Employee Injury/Illness Form and is automatically generated after the injury/illness has been reported to Gallagher Bassett. The First Report of Injury is the official court documentation of the injury/illness.

First Script Pharmacy Card: This card allows an employee to fill prescriptions as no cost immediately after a work-related injury/illness. This card should be given to the employee after reporting a work-related injury/illness and it should never be duplicated. An employee should also not be given this card more than once.

Mileage Reimbursement: An employee may be entitled to reimbursement of mileage expenses to attend medical appointments. The form should be submitted directly to the injured employee's Resolution Manager.

Payroll Benefits (PB) Form: PB forms should be submitted to Gallagher Bassett for each injured employee within 2-3 days prior to processing payroll. The PB Form documents how many hours an employee missed during a pay period and the reason for the absence. Gallagher Bassett uses the reported hours missed to determine the appropriate amount of disability benefits owed to an employee. Once calculated, Gallagher Bassett will return the form (within one business day) to the Agency stating how much the employee is to be paid in disability. If the employee has agreed to have his/her benefits supplemented with sick and/or vacation time, the Agency should also use the PB Form to document the amount of hours supplemented.

Report of Work Ability: Any time an employee sees a doctor, a Report of Work Ability should be completed by the doctor and returned to Agency HR by the employee. Agencies should remind employees to get a Report of Work Ability to take to each visit to the doctor. Again, the form should be completed by the doctor. The employee should bring the form back to work and submit to Agency HR. Employees should not be allowed to return to work without an updated Report of Work Ability on file.

Request to Supplement Workers' Compensation Benefits: This form should be reviewed and signed by an employee upon reporting a work related injury/illness. This form explains that an employee has the option to supplement workers' compensation benefits with any leave previously accrued. If benefits are supplemented, the employee will receive a paycheck for the full amount of average weekly wage. If an employee chooses not to supplement, the employee will only be paid those lost time benefits allowed under workers' compensation.

Supervisor Investigation Report: Supervisors should complete an Investigation Report for every accident. The form should be completed by the supervisor and submitted to Agency HR. This form will be used to assist in the investigation of the workers' compensation claim.

Witness Statement: A Witness Statement form should be completed by each and every witness to a work-related injury. This form should be submitted to Agency HR and will be used to assist in the investigation of the workers' compensation claim.



# Forms:

- 7 Day Wait Period Acknowledgment & Agreement.
- 26 Week Wage Statement.
- Employee Incident Form.
- First Report of Injury.
- Mileage Reimbursement.
- Payroll Benefits (PB) Form.
- Report of Work Ability.
- Request to Supplement Workers' Compensation Benefits.
- Supervisor Investigation Report.
- Witness Statement.

### 7 Day Wait Period Acknowledgment and Agreement

I am an employee of the State of Nebraska, with the [Click Here to Enter Agency Name](#). I work in an employment position covered under NAPE/AFSCME/SLEBEC/F.O.P. #88 Labor Contract or the State of Nebraska Classified System Personnel Rules and Regulations. I have filed a claim for workers' compensation based upon an injury or illness I believe arose out of and in the course of employment.

I understand that under the law, the State is not required to compensate me for any time I am unable to work during the first seven days after a work-related injury or illness. However, the State does allow for use of my sick, vacation, or comp time, or injury leave (if available), to supplement the time I am unable to work during this 7-day period. I give my agency permission to supplement my time off with any sick, vacation, injury leave, or comp time I may have. I acknowledge I have been informed that should my injury/illness be determined as compensable and should my injury/illness continue for six weeks or more, I will be paid workers' compensation benefits for that 7-day waiting period. This is known as retroactive pay and these benefits will be paid by Gallagher Bassett, the State of Nebraska's Third-Party Administrator.

I acknowledge that in the event my agency has supplemented my time off, under my authorization, and I receive retroactive pay, I will be required to repay the State for any injury leave used. The State will also credit me back any sick, vacation, or comp time used. I understand this is necessary to prevent a double payment of compensation. I further acknowledge that the above referenced documents state: 1) NAPE/AFSCME Labor contract - "no employee shall receive a salary (workers' compensation plus regular pay) in excess of his or her normal wage," OR 2) Classified System Personnel Rules and Regulations - "no employee shall receive payments (workers' compensation plus regular pay) in excess of his or her gross wages."

Based upon the foregoing, I expressly authorize the State of Nebraska to deduct from future earnings any amount received by me which is in excess of my normal wage for the 7-day waiting period.

▾

\_\_\_\_\_  
 Employee's Signature

\_\_\_\_\_  
 Print Name

I hereby authorize \_\_\_\_\_ to supplement my time off during the 7-day waiting period by using any sick, vacation or comp time, or injury leave I may have available.

Time Off Benefits	Yes	No	Employee's Initials
Sick			
Vacation			
Comp Time			
Injury Leave			

\_\_\_\_\_  
 Employee's Signature

# NEBRASKA

Good Life. Great Service.

DEPT. OF ADMINISTRATIVE SERVICES

## 26 WEEK WAGE HISTORY

Employee Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

<u>Pay Period</u>	<u>Overtime Paid</u>	<u>OT Hours Worked</u>	<u>Base Hourly Rate</u>	<u>Gross Pay (Reg. Hrs. x Base Rate)</u>	<u>Date Paid</u>

Completed By: \_\_\_\_\_ Title: \_\_\_\_\_



# EMPLOYEE'S CHOICE OR CHANGE OF DOCTOR FORM

## NOTICE TO EMPLOYER:

GIVE THIS FORM TO THE INJURED WORKER AS SOON AS POSSIBLE AFTER EACH INJURY

### PART A: NOTICE REGARDING CHOICE OR CHANGE OF DOCTOR

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 Part B (below) to tell your employer the name of the doctor you choose.

My employer has informed me of the above information regarding choice or change of doctor.

\_\_\_\_\_

[PRINT NAME OF EMPLOYEE]

\_\_\_\_\_

[SIGNATURE OF EMPLOYEE]

\_\_\_\_\_

[DATE]

### PART 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 do not have or I do not wish to choose a doctor who has treated me or an immediate family member.

\_\_\_\_\_

[DOCTOR'S NAME]

\_\_\_\_\_

[SIGNATURE OF EMPLOYEE]

\_\_\_\_\_

[DOCTOR'S ADDRESS]

\_\_\_\_\_

[DATE]

### PART C: USE TO CHANGE THE CHOICE MADE IN PART B, ABOVE

I wish to change my choice of doctor or I wish to choose a doctor to treat me for my work-related injury. I certify the doctor named below has treated me or an immediate family member before this work-related injury. I understand that I cannot make this change unless my employer agrees or unless the Nebraska Workers' Compensation Court orders a change.

\_\_\_\_\_

[DOCTOR'S NAME]

\_\_\_\_\_

[SIGNATURE OF EMPLOYEE & DATE OF SIGNATURE]

\_\_\_\_\_

[DOCTOR'S ADDRESS]

\_\_\_\_\_

[SIGNATURE OF EMPLOYER & DATE OF SIGNATURE]

**Employee Incident Report**

This form must be completed, reviewed with a supervisor and submitted to WCC within 24 hours.

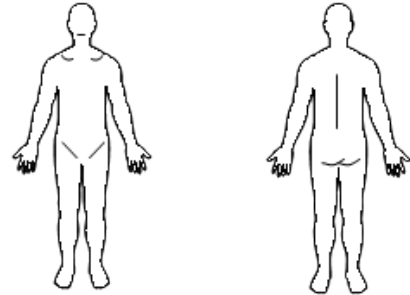
Employee Name (last, first) \_\_\_\_\_ EE#/SS#: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_ Job Title: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Department: \_\_\_\_\_  
 Phone/Cell Number: \_\_\_\_\_ Supervisor: \_\_\_\_\_

Date of Injury/Illness: \_\_\_\_\_ Time Employee Began Work: \_\_\_\_\_ Time of Injury/Illness: \_\_\_\_\_  
 Location of Incident: \_\_\_\_\_ Who was Notified? \_\_\_\_\_  
 Date Employer Notified: \_\_\_\_\_ Last Work Day: \_\_\_\_\_ Date Returned to Work: \_\_\_\_\_  
 Body Part Injured: \_\_\_\_\_ If Fatal, Date of Death: \_\_\_\_\_

Describe incident (describe what happened, how the incident occurred, include details pertaining to equipment, environment, tasks, etc.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Indicate on the Diagram the location of injury



Injury is a:  New or  Re-injury  
 Initial Treatment:  No Medical Treatment:  Emergency Room:   
 First Aid by Employer:  Hospitalized Overnight:   
 Minor Clinic/Hospital:  Hospitalized >24 Hours:

What was the cause of this incident?  
 \_\_\_\_\_

How could this incident have been prevented?  
 \_\_\_\_\_  
 \_\_\_\_\_

Did anyone witness the incident?  Yes  No

If yes, please provide the name and phone number of the witnesses.  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have other employment?  Yes  No If yes, where? \_\_\_\_\_

\_\_\_\_\_  
 Employee Signature

\_\_\_\_\_  
 Date

## Nebraska Workers' Compensation Court First Report of Alleged Occupational Injury or Illness

NWCC Form 1  
Revised 1/00

Employer					
Employer FEIN <u>47-0491233</u>		SIC Code _____		Report Purpose _____ OSHA Log Case # _____	
Employer Name(s) (Agency Information) Address _____ City _____ State _____ Zip Code _____ Phone _____			Insured Name (If different from employer name) Insured Address (If different) _____ Location _____		
Insurance Carrier					
Carrier FEIN <u>47-0491233</u>		Administrator FEIN <u>36-3365500</u>			
Name <u>State of Nebraska</u>		Claim Administrator (Name, address & phone number) <b>Gallagher Bassett Services</b> 10050 Regency Circle, Suite 300 Omaha, NE 68114 Phone: 402-972-4780 Fax: 402-972-4777			
Address <u>1526 "K" Street Suite 220</u>					
City <u>Lincoln</u>					
State <u>NE</u> Zip Code <u>68508</u> Phone <u>402-471-2551</u>		Self Insured <input checked="" type="checkbox"/> Claim Administrator Claim # _____			
Policy Number <u>N/A</u>		Check if Appropriate _____ Jurisdiction Claim # _____			
Policy Period: From <u>N/A</u> To <u>N/A</u>					
Insurance Carrier/Self-Insured Code # _____		Insured Report # _____		Jurisdiction _____	
Employee					
Name (Last, First, Middle) _____		Full Pay for DOI Yes <input type="checkbox"/> No <input type="checkbox"/> Salary Continued Yes <input type="checkbox"/> No <input type="checkbox"/>		Number of Days Worked Per Week _____	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
Address _____		Number of Dependents _____		Occupational Job Title _____	
City _____		Marital Status _____		Occupational Code _____	
State _____ Zip Code _____ Phone _____		Wage \$ _____		NCCI Class Code _____	
Date of Birth _____ Social Security Number _____ Date Hired _____		Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried <input type="checkbox"/> Unknown <input type="checkbox"/>		Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Monthly <input type="checkbox"/>	
				Date Employee Began Work-Related Duties _____	
				Employment Status FT <input type="checkbox"/> PT <input type="checkbox"/> Other <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"/> 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. 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 <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"/> time _____		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 _____



**GALLAGHER BASSETT SERVICES, INC.  
AUTHORIZATION FOR RELEASE OF INFORMATION  
(HIPAA COMPLIANT)**

**Patient Information:**

\_\_\_\_\_ BD: \_\_\_\_\_ SS# \_\_\_\_\_  
(Print Name of Patient)

**Information to be released from:**

\_\_\_\_\_ Name of Designated Facility or Provider

\_\_\_\_\_ Address

\_\_\_\_\_ City, State, Zip Code \_\_\_\_\_ Phone Number

**Information to be sent to:**

GALLAGHER BASSETT SERVICES, INC.  
ATTN: \_\_\_\_\_

\_\_\_\_\_ Name of Designated Recipient

10050 Regency Circle # 300  
\_\_\_\_\_ Address

Omaha, NE 68114 \_\_\_\_\_ 402-972-4780  
City, State, Zip Code Phone Number

**Information to be released:**

- The most recent 2 years of pertinent information (chart notes, labs, X-rays and special tests)
- All medical records
- Specific information (Please specify) \_\_\_\_\_

**Purpose for which disclosure is being made:** Processing of an insurance claim.  
Date of Loss: \_\_\_\_\_

**Patient Authorization:**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

**\* EXCLUDE the following information from the records released (please initial):**

_____	Drug/Alcohol abuse /treatment & diagnosis	_____	Sexually Transmitted Disease
_____	HIV/AIDS diagnosis/treatment/testing	_____	Mental Illness or psychiatric diagnosis/treatment

**My Rights:**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient, Guardian\*, or Authorized Representative\*)  
[\*Please provide documents to prove authority to sign on behalf of the patient]

**SHALL BE VALID FOR ONE YEAR FROM THE ABOVE DATE  
PHOTOCOPY VALID AS ORIGINAL**

**STATE OF NEBRASKA #009006  
MILEAGE REIMBURSEMENT FORM**

**NAME:** \_\_\_\_\_

**DATE OF INJURY:** \_\_\_\_\_

**CLAIM NUMBER (if known)** \_\_\_\_\_

DATE	PROVIDER (NAME OF DOCTOR OR CLINIC)	PURPOSE (EXAM, PT, X-RAYS)	#MILES

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

**Please return completed form to your claim handler via email, or send to:**  
**Gallagher Bassett Services**  
10050 Regency Circle, Suite 300  
Omaha, NE 68114  
Phone: 402-972-4786  
Fax: 402-972-4777

# NEBRASKA

Good Life. Great Service.

DEPT. OF ADMINISTRATIVE SERVICES

## PAYROLL BENEFIT ANALYSIS (BI-WEEKLY)

Employee Name: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Pay Period: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Rate of Pay On Date of Injury: \_\_\_\_\_

Date:	Hours Missed:	Missed Work Code:	Hours Supplemented:	Supplement Code:

**Resolution Manager Only:**

(TPD only) Gross Wages Paid by Employer: \_\_\_\_\_

Workers' Compensation Benefit Paid: \_\_\_\_\_

Wait Period Meet       Retro Pay Paid \_\_\_\_\_

Wait Period Dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Missed Work Codes:		Supplement Codes:
MA - Medical Appointment	HOL - Paid Holiday	S - Sick
DN - Doctor's Note	PI - Personal Illness(not work comp related)	VAC - Vacation
NLD - No Light Duty Available	NWC - Not Work Comp Related	COM - Comp Time
DO - Day Off		IL - Injury Leave

## Workability Form

Associate Name (Last, First): \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Check One:  Initial Visit  Follow-Up  Discharge from Care

Current Treatment Plan: \_\_\_\_\_

**Completed copies of this report must be sent back to XXXX with the associate:**

**Work Status (choose one):**

- Full Duty:** Associate may return to work on (\_\_\_\_/\_\_\_\_/\_\_\_\_) with no restriction or limitations
- No Duty / Temporary:** Associate is physically unable to return to work as of (\_\_\_\_/\_\_\_\_/\_\_\_\_)

NDCS Employees Only:

- Direct Inmate Contact:  Yes  No
- Indirect Inmate Contact:  Yes  No

**Anticipated Return to Work date** (\_\_\_\_/\_\_\_\_/\_\_\_\_) to  **Temporary transitional Duty**  **Full Duty**

**Temporary transitional Duty /Temporary**

Associate may return to work on (\_\_\_\_/\_\_\_\_/\_\_\_\_) with the follow limitations (measured in hours)

Stand/Walk	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Sit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Drive	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Bend/Stoop	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Twist	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Squat/Crouch	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Climb	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Kneel/Crawl	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Overhead Work	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
<b>Lifting and Carrying</b>														
0 – 10 lbs.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
10 – 20 lbs.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
20 – 30 lbs.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
30 – 50 lbs.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
50 – 75 lbs.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
75 – 100 lbs.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
<b>Hands:</b>	<input type="checkbox"/> Left		<input type="checkbox"/> Right		<input type="checkbox"/> Both									
Grasping	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Pinching	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Pulling/Pushing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Fine Manipulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
Keyboarding/typing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16
<b>Feet:</b>	<input type="checkbox"/> Left		<input type="checkbox"/> Right		<input type="checkbox"/> Both									
Foot Controls/Pedal	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 16

If the associate is on medication, will the medication restrict the associate's ability to drive or work safely?  Yes  No

These restrictions are TEMPORARY and will be reassessed on: (\_\_\_\_/\_\_\_\_/\_\_\_\_)

Patient is expected to resume full duty within  24 hrs  48 hrs  30 days  60 days  90 days  120 days  180 days  180+ days

Resume work No Restrictions?  Yes  No Was patient referred to a specialist?  Yes  No

Next office visit date: (\_\_\_\_/\_\_\_\_/\_\_\_\_) If yes, who? \_\_\_\_\_

Print Doctor's Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Doctor's Signature: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

I understand that by signing this form, I am agreeing to furnish a copy to my work location.



**Request to Supplement Workers' Compensation Benefits**

**Employee must complete this form promptly after an injury resulting in lost time.**

1. Employee Name (printed)	2. Date of Injury
3. Social Security Number XXX-XX-	4. Claim Number

If you sustain a disabling on-the-job injury/illness covered by workers' compensation, you may choose to have your workers' compensation benefits supplemented with leave time you have accrued. An employee may use sick, vacation, injury leave, or comp time. If an employee does not have any leave time available, the employee will only receive statutory workers' compensation benefits. An employee may also elect not to supplement workers' compensation benefits with leave time. The choice to supplement benefits may be rescinded by the employee at any time.

5. Total Leave Available:

Sick Hours:	Vacation Hours:
Injury Leave:	Comp Time:

<input type="checkbox"/> 6. I wish to use all of my accrued sick leave.
<input type="checkbox"/> 7. I wish to use all of my accrued vacation leave.
<input type="checkbox"/> 8. I wish to use all of my accrued injury leave.
<input type="checkbox"/> 9. I wish to use all of my accrued comp time.
<input type="checkbox"/> 10. I wish only to use _____ hours of _____ leave.
<input type="checkbox"/> 11. I do not wish to supplement by workers' compensation benefits with leave time.

Click here to enter a date.

\_\_\_\_\_  
Employee's Printed Name

\_\_\_\_\_  
Employee's Signature

<input type="checkbox"/> 12. I wish to rescind the selections identified above. I no longer wish to have my workers' compensation benefits supplemented with leave time.
--

Click here to enter a date.

\_\_\_\_\_  
Employee's Printed Name

\_\_\_\_\_  
Employee's Signature

Supervisors Incident Analysis Report  
STATE OF NEBRASKA INCIDENT INFORMATION

Agency: \_\_\_\_\_ Division: \_\_\_\_\_

Individual Reporting Incident: \_\_\_\_\_

Who Incident was Reported to: \_\_\_\_\_

INDIVIDUAL INVOLVED (ATTACH ADDITIONAL REPORTS IF MORE THAN ONE PERSON WAS INVOLVED)

Name of Person Injury/Involved: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female

DESCRIPTION OF ACCIDENT/ INCIDENT/INJURY/ILLNESS (CHECK ALL THAT APPLY)

Type of Incident:

Minor Injury of Illness     Serious Injury or Illness     Fatality     Other

Incident Location: \_\_\_\_\_

Property Damage:

Yes     No    Product Involved: \_\_\_\_\_

Vehicle Involved:  Yes     No

Other Vehicle Driver: \_\_\_\_\_ Date of Incident: \_\_\_\_\_ License Number: \_\_\_\_\_

Vehicle Make & Model: \_\_\_\_\_ Time of Incident \_\_\_\_\_  AM/PM

Type of Activity during which Incident/Injury occurred: \_\_\_\_\_

First Aid Treatment/Immediate Remedy: \_\_\_\_\_

Root Cause Analysis- What is the root cause(s) of the event? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Recommended Solution/Suggestions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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