# City of Omaha
# Initial Report of Injury on Duty

## Employer

Employer FEIN: 47-6006304 UI# 0160241004 SIC Code: 9199

Business Name: City of Omaha
Address: 1819 Farnam Street
Human Resources Dept. Suite 506
Omaha, NE 68183

Phone: (402) 444-5313
FAX: (402) 444-5314
Web: https://hr.cityofomaha.org

## Employee

Name: *(Last, First, Middle)* _____
Address: _____
_____
City: _____
State: _____ ZIP Code: _____
Phone: _____

# of Days Worked Per Week _____

Sex
Male ☐ Female ☐

Number of Dependents:

Job Title:

Marital Status
Married ☐
Separated ☐
Unmarried ☐
Unknown ☐

Wages
$_____
Hourly ☐
Bi-Weekly ☐

Employment Status
FT ☐ PT ☐ Other ☐

Employee's Work Phone #

| Date of Birth | Social Security Number | Date of Hire | Department/Organization | Supervisor's Name & Phone # |
|---|---|---|---|---|
| | | | | |

## Occurrence/Treatment

| Injury/Illness Date | Injury/Illness Time | Time Employee Began Work | About the Injury/Illness | Medical Attention Requested |
|---|---|---|---|---|
| | AM ☐ _____ PM ☐ | AM ☐ _____ PM ☐ | On Employer's Premise Yes ☐ No ☐ On Duty ☐ Off Duty ☐ | Yes ☐ No ☐ Not at this time ☐ |

Injury/Illness Location

Street Address or Nearest Intersection City County State Zip Code

How Illness/Injury Occurred *(Describe the sequence of events use the back or additional paper as needed.)*

**Internal Use Only**

Cause of Injury Code

List the Objects/Substance that directly caused the injury *(Include any safety concerns you may have)*

Hazardous Materials Exposure ☐

Part of Body Affected *(Indicate the part of the body affect by the injury/illness; e.g., right forearm, lower back)*

Part of Body Code

Is there pain/discomfort on other portions of your body in addition to the injury site? If yes, please explain.

Nature of Injury Code

Type of Illness/Injury *(Briefly describe the nature of the injury or illness; e.g., lacerations to forearm)*

Initial Treatment: *No Medical Treatment* ☐ *First Aid* ☐ *Minor Clinic/Hospital* ☐
*Emergency Care* ☐ *Hospitalization More than 24 Hours* ☐ *Future Major Medical/Lost Time* ☐

Date Administrator Notified

Form Preparer's Name: Title: Phone: Date Prepared