TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Office Mail Address	Location . . . If different from mailing address	Telephone	
City State Zip	INSURER	THIRD-PARTY ADMINISTRATOR	

EMPLOYEE

First Name M.I. Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Home Address (Number and Street)	Sex ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
City State Zip	Was the employee paid for the day of injury? (If applicable) ☐ Yes ☐ No	How long has this person been employed by you in Nevada?		
In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:		
Telephone	Is the injured employee a corporate officer? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No	Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No		

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
Address or location of accident (Also provide city, county, state) (if applicable)		Accident on employer's premises? (if applicable) ☐ Yes ☐ No	

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)		Witness	Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No
Part of body injured or affected	If fatal, give date of death	Witness	
Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
		Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No	Will you have light duty work available if necessary? ☐ Yes ☐ No
If validity of claim is doubted, state reason		Location of Initial Treatment	
Treating physician/chiropractor name		Emergency Room ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No
IMPORTANT	How many days per week does employee work?	From ☐ am ☐ pm To ☐ am ☐ pm	Last day wages were earned

Scheduled days off: S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐

Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No

If not, for how many hours a week was the employee hired?

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail cha@govcha.state.nv.us

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I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.	Employer's Signature and Title	Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer ____

Name of Employee			Social Security Number		Telephone Number	
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)				
What is the nature of the injury or occupational disease?				List any body parts involved:		
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)						
Names of witnesses:						
Did the employee leave work because of the injury or occupational disease? _____ **YES** _____ **NO**		If yes, when (date and time)?		Has the employee returned to work? ____ **YES** ____ **NO**		If yes, when (date and time)?
Was first aid provided? ____ **YES** ____ **NO**		If yes, by whom?		Name and address of treating physician, if applicable or known		
Did the accident happen in the normal course of work? (if applicable) ____ **YES** ____ **NO**						
Was anyone else involved? ____ **YES** ____ **NO**		Names of others involved				

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

______________________________ ______________________________

Supervisor's Signature Date Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

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Employee should sign, date and retain a copy.

Original to Employer, Copy to Employee

State of Nevada

DEPARTMENT OF BUSINESS & INDUSTRY

DIVISION OF INDUSTRIAL RELATIONS

Workers' Compensation Section

ATTENTION

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http:/govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: ______________________ Contact Person: ______________________

Address: ______________________ Telephone Number: ______________________

City State Zip

MCO/Health Care Provider: ______________________ Contact Person: ______________________

Address: ______________________ Telephone Number: ______________________

City State Zip

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

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NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex ☐ M ☐ F	Claim Number (Insurer's Use Only)
Home Address			Age / Height	Weight	Social Security Number
City	State	Zip		Telephone	
Mailing Address	City	State	Zip		Primary Language Spoken

INSURER	**THIRD-PARTY ADMINISTRATOR**	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name	Telephone
Office Mail Address (Number and Street)	

Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?		Witnesses to the Accident (if applicable)
Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected	

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date Place Employee's Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place	Name of Facility

Date / Hour	Diagnosis and Description of Injury or Occupational Disease	Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (if yes, please explain)

Treatment:	Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from ____________ to __________________ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty If modified duty, specify any limitations/restrictions: ______________________
X-Ray Findings:	
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No	
Is additional medical care by a physician indicated? ☐ Yes ☐ No	

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date	Print Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:

Address			INSURER'S USE ONLY
City State Zip	Provider's Tax I.D. Number	Telephone	
Doctor's Signature		Degree	

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR **PAGE 2 – INSURER/TPA** **PAGE 3 – EMPLOYER** **PAGE 4 – EMPLOYEE**