

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

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? . . . sole proprietor? . . . partner? Yes No Yes No 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. Time began work.												
INJURY OR DISEASE	Specify machine, tool, substance, or object most closely connected with the accident					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		To			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	
	Date employee was hired		Last day of work after injury or disability				Date of return to work			Number of work days lost			
IMPORTANT LOST TIME INFO	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	Employee is paid:	WEEKLY	MONTHLY	OTHER	On the date of injury or disability the employee's wage was: \$ per Hr Day Wk Mo		
	MON	WED	FRI	BI-WKLY	SEMI-MONTHLY								
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													
Insurer Use Only	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			
	Claim is: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> 3 rd 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).

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

Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

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

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 required 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. 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 the 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