

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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed													
	City		State		Zip		Was the employee paid for the day of injury? (If applicable) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No						Was employee in your employ when injured or disabled by occupational disease (O/D)? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No			Will you have light duty work available if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No												
	If validity of claim is doubted, state reason						Location of Initial Treatment															
	Treating physician/chiropractor name						Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No			Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No												
IMPORTANT	How many days per week does employee work?				From		<input type="checkbox"/> am <input type="checkbox"/> pm		To		<input type="checkbox"/> am <input type="checkbox"/> pm		Last day wages were earned									
	Scheduled days off		S		M		T		W		T		F		S		Rotating <input type="checkbox"/>		Are you paying injured or disabled employee's wages during disability? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> SUN <input type="checkbox"/> TUE <input type="checkbox"/> THUR <input type="checkbox"/> SAT <input type="checkbox"/> MON <input type="checkbox"/> WED <input type="checkbox"/> FRI				Employee is paid: <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER <input type="checkbox"/> BI-WKLY <input type="checkbox"/> SEMI-MONTHLY				On the date of injury or disability the employee's wage was: \$ _____ per <input type="checkbox"/> Hr <input type="checkbox"/> Day <input type="checkbox"/> Wk <input type="checkbox"/> Mo													
<p>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</p>																						
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								

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT

FORM C-4

PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

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First Name	M.I.	Last Name	Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)			
Home Address			Age	Height	Weight	Social Security Number		
City	State		Zip		Telephone			
Physical 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					
<p style="font-size: small; color: red;">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.</p>								
Date	Place	Employee's Signature						
THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT								
Place	Name of Facility							
Date	Diagnosis and Description of Injury or Occupational Disease			<p style="color: red;">Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)</p>				
Hour								
Treatment:			<p style="color: red;">Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____</p>					
X-Ray Findings:			<p style="color: red;">From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="color: red;">Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p style="color: red;">Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)</p>								
Date	Print Doctor's Name		<p style="color: red;">I certify that the employer's copy of this form was mailed to the employer on:</p>					
Address				INSURER'S USE ONLY				
City	State	Zip	Provider's Tax I.D. Number				Telephone	
Doctor's Signature			Degree					

