

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

Reset Form

Print Form

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER	Employer's Name	Nature of Business (mfg, etc.)	FEIN	OSHA Log Number
	Office Mail	Location . . if different from mailing address	Telephone Number	
	City, State, Zip Code	INSURER	THIRD PARTY ADMINISTRATOR	

EMPLOYEE	First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken	
	Home Address (Number and Street)			Sex	Marital Status			
				<input type="checkbox"/> Male <input type="checkbox"/> Female	<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?		How long has this person been employed by you in Nevada?		
				<input type="checkbox"/> Yes <input type="checkbox"/> No				

ACCIDENT OR DISEASE	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?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
	<input type="checkbox"/> Corporate Officer <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partner		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Date of Injury (if applicable)		

INJURY OR DISEASE	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)
	What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)			<input type="checkbox"/> Yes <input type="checkbox"/> No
	How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.			
	Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness		Was more than one person injured in this accident? (if applicable)

IMPORTANT LOST TIME INFO	Part of body injured or affected	If fatal, give date of death	Witness	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)		Witness	
	If validity of claim is doubted, state reason .		Did employee return to work next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Treating physician/chiropractor name		Location of Initial Treatment	Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No

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
IMPORTANT					

Scheduled Days Off	Are you paying injured or disabled employee's wages during disability?	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> Rotating	<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		
Was the employee hired to work 40 hours per week? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, 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
For the purpose of calculation of the average monthly wage, indicate the employee's gross earning 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:	Employee is paid:	On the date of injury or disability the employee's wage was:
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other <input type="checkbox"/> BiWeekly <input type="checkbox"/> Bi-Monthly	per <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Day <input type="checkbox"/> Month
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		
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:	Deemed Wage	Account No.	Class Code
	<input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> Third-Party			
Claims Examiner's Signature	Date	Status Clerk	Date	