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 ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

City | State | Zip

Was the employee paid for the day of injury? ☐ 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? ☐ Corporate Officer ☐ Sole Proprietor ☐ Partner

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 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 work 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 LOST TIME INFO

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

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 no, 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

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 renumeration, 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 hireto the date of injury or disability.

Pay Period ends on: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Employee is paid: ☐ Weekly ☐ Monthly ☐ Other ☐ BiWeekly ☐ Bi-Monthly

On the date of injury or disability the employee's wage was: _____ per ☐ Hour ☐ Week ☐ Day ☐ 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: ☐ Accepted ☐ Denied ☐ Deferred ☐ Third-Party

Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

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