

"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	
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 C4).

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