

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	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.													
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) 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								
	If validity of claim is doubted, state reason					Did employee return to next scheduled shift after accident? (if applicable) Yes No			Will you have light duty work available if necessary? Yes No					
	Treating physician/chiropractor name					Location of Initial Treatment			Hospitalized Yes No					
	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			
IMPORTANT LOST TIME INFO	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 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			
<p>For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA/ E-mail: cha@govcha.nv.gov</p>														
*	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 3 rd Party			Deemed Wage			Account No.			Class Code				
	Claims Examiner's Signature			Date			Status Clerk			Date				