

**EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT**

EMPLOYEE'S CLAIM-- PROVIDE ALL INFORMATION REQUESTED

First Name _____ M.I. _____ Last Name _____ Birthdate _____ Sex M F Claim Number (insurer's use only) _____

Home Address _____ Age _____ Height _____ Weight _____ Social Security Number _____

City _____ State _____ Zip Code _____ Telephone _____

Mailing Address _____ City _____ State _____ Zip Code _____ 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) _____ Hour of Injury 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 the 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? _____

Nature of injury or occupational disease _____ Part(s) of body injured or affected _____

Witnesses to the accident (if applicable) _____

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 DISEASE 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.

Date _____ Place _____ Employee's Signature _____

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place _____ Name of Facility _____

Date _____ Hour _____ Diagnosis and description of injury or occupational disease _____

Is there evidence that the injured employee was under the influence of alcohol and/or an other controlled substance at the time of the accident? No Yes

If yes, please explain _____

Treatment _____ Have you advised the employee to remain off work five days or more? Yes If yes, indicate dates: _____ to _____ No If no, is the injured employee capable of Full Duty Light Duty

X-ray findings _____

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? Yes No

Is additional medical care by a physician indicated? Yes No

If modified duty, list any limits or restrictions. _____

Do you know of any previous injury or disease contributing to this condition or occupational disease? If yes, explain _____

Date _____ Print Doctor's Name _____ I certify that a copy of this form was mailed to the employer on: _____

Address _____ City _____ State _____ Zip _____ Telephone _____

Doctor's Signature _____ Degree _____

INSURER'S USE ONLY