Reset Form

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

Print Form

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?

Witnesses to the accident (if applicable)

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

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). IHEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTIIONER 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 INORMATION, 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 M UST 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 | Diagnosis and description of injury or occupational disease

Hour

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 inury 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

ORIGINAL - TREATING PHYSICIAN OR CHIROPRACTOR COPY 1 - INSURER/TPA COPY 2 - EMPLOYER COPY 3 - EMPLOYEE FORM C-4 (REV10/07)