State of Nevada

Department of Business and Industry

Division of Industrial Relations

*Workers’ Compensation Section*

OCCUPATIONAL DISEASE CLAIM REPORT

NRS 617.357

STATEMENT OF INACTIVITY

CALENDAR YEAR

### Workers’ Compensation Insurers

**(To be submitted in lieu of the Occupational Disease Claim Report Form, OD-8)**

## SUBMIT WITHIN 5 WORKING DAYS OF THE END OF THE CALENDAR YEAR WITH NO ACTIVITY

# Workers’ Compensation Section

# 3360 W. Sahara Ave., Suite 250

##### Las Vegas, NV 89102

#### Attention: Research and Analysis Unit

Fax: (702) 486-8712

Email: [wcsra@dir.nv.gov](mailto:wcsra@dir.nv.gov)

**I certify that there has been no occupational disease claims activity pursuant to NRS 617.357 during the indicated calendar year for the workers' compensation insurer named below:**

|  |
| --- |
| **Insurer Name:** |
| **Nevada Certificate of Authority Number:** |
| NCCI Carrier Code (Private Carriers): |
| Federal Employer Identification Number (FEIN): |

|  |  |  |
| --- | --- | --- |
| **Name:** | | |
| **Title:** | | |
| **Organization:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Telephone:** | **Fax:** | |
| **Email Address:** | | |

|  |  |
| --- | --- |
|  |  |
| **Signature** | **Date** |