State of Nevada
Division of Industrial Relations

Workers' Compensation
&
Nevada Employers

WORKERS' COMPENSATION SECTION

WCS Mission Statement

Impartially serve the interests of Nevada employers and employees by providing assistance, information, and a fair and consistent regulatory structure focused on:

- **Ensuring the timely and accurate delivery of workers' compensation benefits**
- **Ensuring employer compliance with the mandatory coverage provisions**

Why Workers' Compensation?

- No-Fault
  - Benefits to Employees
  - Protection for Employers
- "Exclusive Remedy"
- Mandatory Workers' Compensation Insurance Coverage with Approved Carrier

Employer Posting Requirements

(Form D-1) Pursuant to NRS 616A.490 & NAC 616A.460

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

ATTENTION

Caution: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer … **shall provide and secure compensation** … **for any personal injuries by accident sustained by an employee arising** out of and in the course of the employment. See NRS 616B.612(1).

An **employer is defined as**, "Every **person, firm, voluntary association** and private corporation, including any public service corporation, which has in service any person under a **contract of hire.**" See NRS 616A.230(2). "A **person is not an employer** … **if (a)The person enters into a contract with another person or business** which is an independent **enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise.**" See NRS 616B.600(1).

An **employee is broadly defined as**, "… every **person in the service of an employer** under any appointment or contract of hire or apprenticeship, express or implied, oral or written, **whether lawfully or unlawfully employed**" (See NRS 616A.105), **but excludes casual employees not in the same trade, business,** profession or occupation; musicians not being more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or key readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is **defined as**, "… **any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished.**" See NRS 616A.255.

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your **workers' compensation insurer, if it has contracted with an Organization for Managed Care** (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payment is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within **30 days of the Appeal Officer's decision. You may be represented** by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge as an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or
2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a **complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers'** Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775)684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1- 888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: _____ Contact Person: _____
Address: _____ Telephone Number: _____
City State Zip
MCO/Health Care Provider: _____ Contact Person: _____
Address: _____ Telephone Number: _____
City State Zip

D-1 (rev. 11/18)

- **Must be posted in proper size (11" X 17")**
- **Most Current poster (11/19)**
- **Provided by Insurer/TPA**
- **The bottom section must be filled out completely**

Employer Posting Requirements

Form D-22

Notice to Employees

Tip Information

(NAC 616A.470)

NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation**.

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

Other Employer Requirements

- Information to Employees
  - Policies/Procedures
  - Who is Employer/Insurer
  - Where to go for treatment/Managed Care Organization (MCO)/Preferred Provider Organization (PPO)
  - Notice of Injury or Occupational Disease (Form C-1)
  - Employers Report of Industrial Injury or Occupational Disease (Form C-3)

Notice Of Injury Or Occupational Disease (Form C-1) - NRS 616C.015

- Incident Report
- Completed within 7 days of accident by injured employee and signed by both employee and employer
- Furnished to employee by employer
- Furnished to employer by Insurer
- Employer to maintain sufficient supply of blank forms
- Completed forms retained by employer for 3 years

"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	If yes, when (date and time)?
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 C-4).

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

C-1 (Rev. 10/09)

Employee's Claim For Compensation/Report Of Initial Treatment - Form C-4

- NRS 616C.040
- Completed by employee and medical provider
- Employee has 90 days to seek treatment
- Medical provider has 3 working days
  - to complete, and
  - mail to employer and CORRECT Insurer/Third Party Administrator (TPA)
- Furnished by medical provider (Workers' Compensation Section website)
- Medical provider to maintain sufficient supply Physician/Chiropractor fined - per violation (Max $1000)

Form C-4

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 | Telephone

Physical Address | City | State | Zip | 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) | Hours Injury (if applicable) 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 this 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 DISEASES 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 another controlled substance at the time of the accident?
☐ No ☐ Yes (If yes, please explain)

Treatment:

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

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty
If modified duty, specify any limitations/restrictions: _____

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

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

Address | INSURER'S USE ONLY

City | State | Zip | Provider's Tax I.D. Number | Telephone

Doctor's Signature | Degree

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE

Form C-4 (rev.01/03)

Employer's Report Of Industrial Injury Or Occupational Disease – Form C-3

- NRS 616C.045
- Furnished to employer by Insurer/Third Party Administrator (TPA) Completed by employer in its entirety
- Upon receipt of Form C-4, employer has 6 working days to complete and mail to Insurer/TPA
- Copy to Employee from the Employer

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? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ 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 | Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason | Location of Initial Treatment

Treating physician/chiropractor name | Emergency Room ☐ Yes ☐ No | 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 ☐ MON ☐ WED ☐ FRI | Employee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY | On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

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

★ 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 ☐ 3rd Party | Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

Form C-3 (rev.11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

Employer Compliance Unit

- Employer Compliance Investigations
- Cancellation/Lapse Investigations
- Uninsured Claim Investigations
  - The uninsured injured worker may choose: Assign to Uninsured Claims Account
  - Employee Election for Compensation (Form D-16)
  - Employee's Claim for Compensation (D-17)

Employer Compliance Unit

- If Coverage Lapse/No Coverage
  - Issue Administrative Fines
  - Premium Penalties
    - Order to pay missed premiums from uncovered period
  - Order Closure of Business

Worker Misclassification

- Employer Misclassification of workers is a growing problem.
- Worker Misclassification occurs when employers misclassify their employees as "independent contractors" in order to eliminate the employer/employee relationship.
- A 1099 or contract does not always eliminate the employer/employee relationship
- Employers must examine their employment relationships before deeming their employees as "independent contractors"

Worker Misclassification

- NRS 616B.603 pertains to Independent Enterprises and should be considered to determine if you could be deemed an employer under this provision.

In order to not be deemed the employer under the "independent enterprise exemption," 1) You must not be "in the same trade, business, profession or occupation" as the person or business with whom you contract, and 2) The person or business with whom you contract must be an independent enterprise. Otherwise, workers' compensation coverage is required.

Incorrectly deeming employees as independent contractors can lead to serious consequences.

Workers' Compensation Myths and Realties

Myth: Family and/or part-time employees do not require coverage

Reality: WC coverage is required

Myth: The subs that I hire should have their own coverage, so I won't worry about workers' compensation insurance.

Reality: If you are a licensed contractor, you should know that you may be determined to be the employer of independent contractors, subcontractors and their employees for purposes of providing workers compensation insurance coverage.

Note: If an employee of a subcontractor or an independent contractor has a work-related injury and the employer has not secured industrial insurance, the principal contractor will be responsible for the actual cost of the claim, plus administrative fees.

Uninsured Employer Consequences

Employers who fail to secure and maintain a workers' compensation policy for their employees will be charged with an administrative fine up to $15,000.

Employers will pay a premium penalty for the time the employer was uninsured.

Employer and will be held financially responsible for all costs relating to an uninsured claim.

Possible criminal prosecution from the Attorney General's Office

WCS Website

http://dir.nv.gov/WCS/home/

State of Nevada Department of Business & Industry

Industrial Relations (DIR)

NV.gov Agencies Jobs Feedback

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Search This Site Search All Sites

ADA Assistance PRINT

HOME | LABOR STATS | MECHANICAL | MINES | OSHA | SCATS | WORKERS' COMP | CONTACT

WELCOME TO WORKERS' COMPENSATION

What's Hot!

- Hearings / Workshops / Meetings
- Current Newsletter
- Training
- Important Changes
- Join our Mailing List
- Adopted Amendment of NAC 616C.502 and Repeal of NAC 616C.498 (LCB File No. R127-17)
- Forms and Worksheets
- WCS Contacts
- Questions? - Please Use WCSHelp

COVERAGE VERIFICATION SERVICE | INJURED WORKERS | EMPLOYER COMPLIANCE | WORKERS' COMPENSATION NEVADA LAW | INSURER AND TPA REPORTING | CLAIMS AND REGULATORY DATA SYSTEM (CARDS)

MEDICAL UNIT

- Current Rating Panel
- Current Treating Panel
- 2019 Medical Fee Schedule
- D-35 Form
- The Pulse Medical Unit Newsletters

INJURED WORKERS

- Northern Complaint Form
- Southern Complaint Form
- Appeal Rights
- Claim Reopening
- Nevada Attorney for Injured Workers

INSURERS / TPAS

- Time Frames
- Standard Audit Requirements
- Subsequent Injury Accounts
- CARDS Brochure
- Claims Indexing (D-38) Brochure

EMPLOYERS

- Employee Leasing Company (PEO)
- Posting Requirements
- SilverFlume
- Uninsured Employers

Employer Coverage Requirements

Post Requirements

Employer Information Page

Subsequent Injury Info

Join WCS Email List

Helpful Newsletter

Coverage Verification

Coverage Verification Service

WC COVERAGE VERIFICATION

Nevada Division Of Industrial Relations

1 LOGIN

Employer | FEIN

State *
Nevada

Coverage Date *
12/23/2019

Employer Name *

Contains Starts With

SEARCH CLEAR

Limitation of Information

The information provided on this web page is a segment of policy information reported to the Nevada Division of Industrial Relations, Workers' Compensation Section by private workers' compensation insurance carriers. Reporting delays, inaccuracies and omissions may affect the reliability of the coverage information provided. Self-insured employers and associations of self-insured employers are not included in the data.

Other Helpful Links

Nevada Division of Industrial Relations, Workers' Compensation Section

Nevada Divison of Insurance - Self-Insured

Doing Business as ... "My Nevada" State Portal Business Licenses.

Contacting WCS

400 West King Street
Suite 400
Carson City, NV 89703
Phone (775) 684-7270
Fax (775) 687-6305

3360 West Sahara Avenue
Suite 250
Las Vegas, Nevada 89102
Phone (702) 486-9080
Fax (702) 486-8712

Email: WCSHelp@dir.nv.gov