

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 <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)	
Home Address			Age	Height	Weight	Social Security Number
City		State	Zip		Telephone	
Mailing 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	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? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)			
Hour						
Treatment:		Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____ _____ _____				
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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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						
City	State	Zip	Provider's Tax I.D. Number	Telephone		INSURER'S USE ONLY
Doctor's Signature				Degree		