REQUEST FOR HEARING - UNINSURED EMPLOYER

REPLY TO:

Department of Administration
Hearings Division - Appeals Officer
1050 E. William Street, Ste. 450
Carson City, NV 89701
(775) 687-8420

OR

Department of Administration
Hearings Division - Appeals Officer
2200 S. Rancho Drive, Suite 220
Las Vegas, NV 89102
(702) 486-2525

____
Injured Employee's Name (Last, First, M.I.)

_______________________________ Claim No. ______________
Address (P.O. Box/Apt./Street)

____
City/State/Zip Code Telephone No. Date of Injury

____
Employer's Name Account No.

____
Address Employer's Phone No.

____
City/State/Zip Code Employer's Representative

I hereby request a hearing before the Appeals Officer to review the determination made by the Administrator of the Division of Industrial Relations regarding Employer/Employee relationship in the designated claim above.

The determination relates to (please mark appropriate space):

___________ Assignment of claim to the Uninsured Employers' Claim Account

___________ Non-assignment of claim to Uninsured Employers' Claim Account

Briefly explain the basis for this appeal:

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This request for hearing is filed by, or on behalf of:

❑ **The Injured Employee**
❑ **The Employer**

and is dated this _________________ day of ______________________________, 20_____________.

_______________________________ _______________________________
Signature of Injured Employee/Employer Injured Employee's/Employer's Rep. (Advisor)

D-12b (Rev. 02/08)