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:

_____

_____

_____

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)