EMPLOYEE'S CLAIM FOR COMPENSATION - UNINSURED EMPLOYER

Mail to: DIVISION OF INDUSTRIAL RELATIONS – WORKERS' COMPENSATION SECTION
400 W. KING STREET, SUITE 400 OR 3360 W. SAHARA AVENUE, SUITE 250 Claim Number _____
CARSON CITY NEVADA 89703 LAS VEGAS, NV 89102

EMPLOYEE First Name M.I. Last Name Soc. Sec. No. Birth Date

Home Address (Number and Street) City State Zip Telephone

Mailing Address Occupation (Job Title) Name of Immediate Supervisor

Sex: Marital Status: No. of Dependents Union Affiliation
Male [ ] Female [ ] Single [ ] Married [ ] Divorced [ ] Widow/er[ ]

Date Hired Where Were You Hired?

How Many Persons Are Employed In This Business? Names of Other Employees (Use Additional Sheets if Necessary)
1. 2. 3.

EMPLOYER Owner's Name First M.I. Last Name Soc. Sec. No. Telephone

Owner's Address Number and Street City State Zip

Name of Business Business Address (Number and Street) City State Zip Telephone

Nature of Business (Manufacturing, Etc.)

ACCIDENT/OCCUPATIONAL DISEASE

Date of Injury or Date You Learned of Disability and Its Relationship to Your Employment

Hour of Injury (if applicable) A.M. [ ] P.M. [ ]

Date Employer Notified of Injury/Occupational Disease

Address Where The Accident Occurred (if applicable)

What Were You Doing When Accident Occurred? (Loading Truck, Walking Down Stairs, Etc.) (if applicable)

How Did Accident or Occupational Disease Occur? (Be Specific and in Detail; Use Additional Sheets if Necessary)

Specify Machine, Tool, Substance, Condition or Object Most Closely Connected With Accident or Occupational Disease

Nature of Injury or Occupational Disease (Scratch, Cut, Bruise, Etc.)

Part(s) of Body Injured (if applicable) Side Injured (if applicable) To Whom Was Injury or Occupational Disease Reported?
Right [ ] Left [ ] Both [ ]

Were There Witnesses to Accident? (Give Names) (if applicable)

Last Paid On Wage $ per How Are You Paid? Cash [ ] Check [ ]

Did You Return to Next Scheduled Shift After Accident? Yes [ ] No [ ] Last Day Worked Date Returned To Work What Are Your Normal Work Days?

TREATMENT Doctor Who Treated You for This Injury or Occupational Disease Doctor's Address

Date of Visit Hour of Visit A.M. [ ] P.M. [ ] Were You Hospitalized? Yes [ ] No [ ]

Name of Hospital Address of Hospital (if applicable)

How Were You Transported From the Place of Accident to the Place of Treatment (Car, Ambulance, Etc.)? Who Provided This Transportation?

I declare under penalty of perjury that the answers above are true and correct to the best of my knowledge.

Date _____ Signature _____

I hereby elect to receive compensation under the provisions of chapters 616A to 616D, inclusive or chapter 617 of the Nevada Revised Statutes (NRS), and do by separate assignment, make an irrevocable assignment of subrogation pursuant to NRS 616C.215 to the Division of Industrial Relations.

Date _____ Signature _____ D-17 (rev.06/18)