

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY

Division of Industrial Relations
400 West King Street, Suite 400 3360 West Sahara Avenue, Suite 250
Carson City, Nevada 89703 Las Vegas, Nevada 89102

FATALITY REPORT
(Pursuant to NAC 616B.018)

(Note: The insurer must notify the Administrator within 48 hours after receiving notice of fatality)

To: ADMINISTRATOR, D.I.R.

From: _____

Address: _____

Date: _____

Deceased: _____ D.O.B. _____ SSN: _____

Address: _____ City: __ County: _____

_____ State: _____

Date of Accident or onset of Occupational Disease: _____ Time: _____ A.M.
P.M.

Date of Death: _____

Marital Status: _____ Name of Spouse: _____ No. of Dependents: _____

Name of Dependent: _____ D.O.B. _____ Relationship: _____

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Employer: _____ Type of Business: _____

Address: _____

Deceased Employee's Occupation: _____

Exact Location of Accident (if applicable): _____

Describe Accident or Occupational Disease: _____

Reported By

Title