Claim Number _____

INJURED EMPLOYEE'S REQUEST FOR COMPENSATION
(Pursuant to NRS 616C.475(6))

ANSWER ALL QUESTIONS, DATE, SIGN AND RETURN TO YOUR CLAIMS AGENT

1. Name: _____ Social Security # _____ Phone No: _____
2. Physical address: _____
   Street City State Zip
   Mailing address: _____
   Street/P.O.Box City State Zip
   Is this a change of address? [ ] Yes [ ] No
3. Employer at time of injury: _____
4. Supervisor's name: _____
5. Name of your attending physician or chiropractor:_____
6. Date on which you were last examined by attending physician or chiropractor: _____
7. Date of next appointment with physician or chiropractor: _____
8. a. Have you been released to return to work by your attending physician or chiropractor? [ ] Yes [ ] No
   b. If so, give the date of release: _____
9. a. Have you returned to work with another employer? [ ] Yes [ ] No
   b. Are you receiving payment from any employer? [ ] Yes [ ] No
   c. Date on which you returned to work: _____
   d. Name of employer for whom you returned to work: _____
   e. Address: _____
10. Have you been disabled and unable to work in <u>any</u> <u>occupation</u> for at least 5 consecutive days, or 5 cumulative days within a 20 day period? [ ] Yes [ ] No
11. Date on which you last worked: _____ For Whom: _____
12. When do you expect to be able to return to your regular occupation? _____
13. Would you be able to work at a light duty type job now? [ ] Yes [ ] No
    Comment: _____
    _____
    _____
14. Has your employer offered you a light duty type job? [ ] Yes [ ] No
    a. If yes, when was the light duty job offered? _____

Per NRS 616D.300, I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits. Further, I understand falsification may subject me to civil and criminal penalties. I certify the above information is correct to the best of my knowledge.

_____ _____
Date Signature

_____
CITY COUNTY STATE

NOTE: An explanation of the methods used to calculate your average monthly wage and compensation benefits should accompany your first compensation check. If you did not receive this, please contact your claims agent.

FOR CLAIMS AGENT'S USE ONLY

PAY: From _____ To _____ Rev. date _____
From _____ To _____ TT Final TT TP

_____ _____
Date Signature