Reset Form

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer _____

Name of Employee		Social Security Number	Telephone Number
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)	
What is the nature of the injury or occupational disease?		List any body parts involved:	
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)			
Names of witnesses:			
Did the employee leave work because of the injury or occupational disease? ____ YES ____ NO	If yes, when (date and time)?	Has the employee returned to work? ____ YES ____ NO	If yes, when (date and time)?
Was first aid provided? ____ YES ____ NO	If yes, by whom?	Name and address of treating physician, if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ☐ YES ☐ NO			
Was anyone else involved? ____ YES ____ NO	Names of others involved		

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature Date

Signature of Injured or Disabled Employee Date

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

For assistance with Workers' Compensation Issues you may contact the State of Nevada for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

Employee should sign, date and retain a copy.

Original to Employer, Copy to Employee

C-1 (Rev. 02/20)