EMPLOYEE'S CLAIM FOR COMPENSATION - UNINSURED EMPLOYER

Mail to: DIVISION OF INDUSTRIAL RELATIONS – WORKERS' COMPENSATION SECTION
1886 EAST COLLEGE PKWY, SUITE 100 OR 3360 WEST SAHARA AVE. SUITE 250
CARSON CITY, NEVADA 89706 LAS VEGAS, NV 89102

Claim Number ____________________

EMPLOYEE

First Name	M.I.	Last Name	Social Security Number	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. 4.

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	How Are You Paid? Cash [ ] Check [ ]
	$ per	

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 ______________________________