

# EMPLOYEE'S CLAIM FOR COMPENSATION - UNINSURED EMPLOYER

Mail to: DIVISION OF INDUSTRIAL RELATIONS – WORKERS' COMPENSATION SECTION  
1886 EAST COLLEGE PKWY, SUITE 100 OR 2300 WEST SAHARA AVE. SUITE 300 Claim Number \_\_\_\_\_  
CARSON CITY, NEVADA 89706 LAS VEGAS, NV 89102

<b>EMPLOYEE</b>	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: Male <input type="checkbox"/> Female <input type="checkbox"/>	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow/er <input type="checkbox"/>	No. of Dependents	Union Affiliation		
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.		

<b>EMPLOYER</b>	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.)						

<b>ACCIDENT/ OCCUPATIONAL DISEASE</b>	Date of Injury or Date You Learned of Disability and Its Relationship to Your Employment	Hour of Injury (if applicable) A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>	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) Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>	To Whom Was Injury or Occupational Disease Reported?	
Were There Witnesses to Accident? (Give Names) (if applicable)			
Last Paid On	Wage \$ _____ per Last Day Worked	How Are You Paid? Cash <input type="checkbox"/> Check <input type="checkbox"/>	
Did You Return to Next Scheduled Shift After Accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Returned To Work	What Are Your Normal Work Days?	

<b>TREATMENT</b>	Doctor Who Treated You for This Injury or Occupational Disease	Doctor's Address
Date of Visit	Hour of Visit A.M. <input type="checkbox"/> P.M. <input type="checkbox"/>	Were You Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
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.09/24)