

**STATE OF NEVADA  
DEPARTMENT OF BUSINESS AND INDUSTRY  
Division of Industrial Relations**

1886 East College Pkwy,  
Suite 100  
Carson City, Nevada 89706

3360 West Sahara Avenue,  
Suite 250  
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 a 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: \_\_\_\_\_ AM \_\_\_ PM

Date of Death: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_ No of Dependents: \_\_\_\_\_

Name of Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of Dependent: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship: \_\_\_\_\_

Employer: \_\_\_\_\_ Type of Business: \_\_\_\_\_

Address: \_\_\_\_\_

Deceased Employee's Occupation: \_\_\_\_\_

Exact Location of Accident (if applicable):

Describe Accident or Occupational Disease:

Reported By: \_\_\_\_\_

Title: \_\_\_\_\_