DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS/WORKERS' COMPENSATION SECTION
400 West King Street, Suite 400 Carson City, Nevada 89703
Telephone: (775) 684-7270 Fax: (775) 687-6305

COMPLAINT FORM

Last Name	**First Name**		**Social Security No.**	
Home Address	**City**	**State**	**Zip Code**	**Home Phone No.**
Employer	**Work Phone No.**	**Date of Injury**	**Claim No.**	
Insurer/Third Party Administrator	**Address**		**Phone Number**	

WHAT DO YOU WISH TO ACCOMPLISH WITH THIS COMPLAINT?

CIRCUMSTANCES LEADING YOU TO FILE THIS COMPLAINT*:

Note: If additional space is required, please attach additional sheets, along with any available documentation.

☐ I have contacted the Nevada Attorney for Injured Workers.

☐ I have contacted the Office of Consumer Health Assistance.

_____ _____

COMPLAINANT'S SIGNATURE DATE

*IF YOU ARE REQUESTING A BENEFIT PENALTY, YOU MUST CITE THE SPECIFIC SECTION(S) AND SUBSECTION(S) OF NRS 616D.120(1) AND ANY OTHER STATUTE OR REGULATION YOU ALLEGE WERE VIOLATED. FAILURE TO PROVIDE THIS INFORMATION MAY RESULT IN REJECTION OF YOUR COMPLAINT AND REQUIRE RESUBMISSION.