

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) 687-3073

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

Complaint form CC (Rev. 4/2023)

***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.**