State of Nevada

Department of Business and Industry

Division of Industrial Relations

*Workers’ Compensation Section*

OCCUPATIONAL DISEASE CLAIM REPORT

NRS 617.357

STATEMENT OF INACTIVITY

CALENDAR YEAR

### Workers’ Compensation Insurers

**(To be submitted in lieu of the Occupational Disease Claim Report Form, OD-8)**

## SUBMIT WITHIN 5 WORKING DAYS OF THE END OF THE CALENDAR YEAR WITH NO ACTIVITY

# Workers’ Compensation Section

# 3360 W. Sahara Ave., Suite 250

##### Las Vegas, NV 89102

#### Attention: Research and Analysis Unit

Fax: (702) 486-8712

Email: wcsra@dir.nv.gov

**I certify that there has been no occupational disease claims activity pursuant to NRS 617.357 during the indicated calendar year for the workers' compensation insurer named below:**

|  |
| --- |
| **Insurer Name:**  |
| **Nevada Certificate of Authority Number:**  |
| NCCI Carrier Code (Private Carriers):       |
| Federal Employer Identification Number (FEIN):       |

|  |
| --- |
| **Name:**  |
| **Title:**  |
| **Organization:**  |
| **Address:**  |
|  **City:**  | **State:**  | **Zip:**  |
| **Telephone:**  | **Fax:** |
| **Email Address:**  |

|  |  |
| --- | --- |
|  |  |
| **Signature** | **Date** |