State of Nevada
Division of Industrial Relations


# Workers' Compensation and Nevada Employers

WORKERS' COMPENSATION SECTION

# In this training, participants will learn about:

- Mission Statement of the Workers' Compensation Section
- What is Workers' Compensation?
- Workers' Compensation forms
- Employer responsibilities
- Different units of the Workers' Compensation Section
- Worker Misclassification, Myths and Realities etc.
- More employer resources

## Workers' Compensation Section

# MISSION STATEMENT

Impartially serve the interests of Nevada employers and employees by providing assistance, information, and a fair and consistent regulatory structure focused on:

- ➢ Ensuring the timely and accurate delivery of workers' compensation benefits
- ➢ Ensuring employer compliance with the mandatory coverage provisions

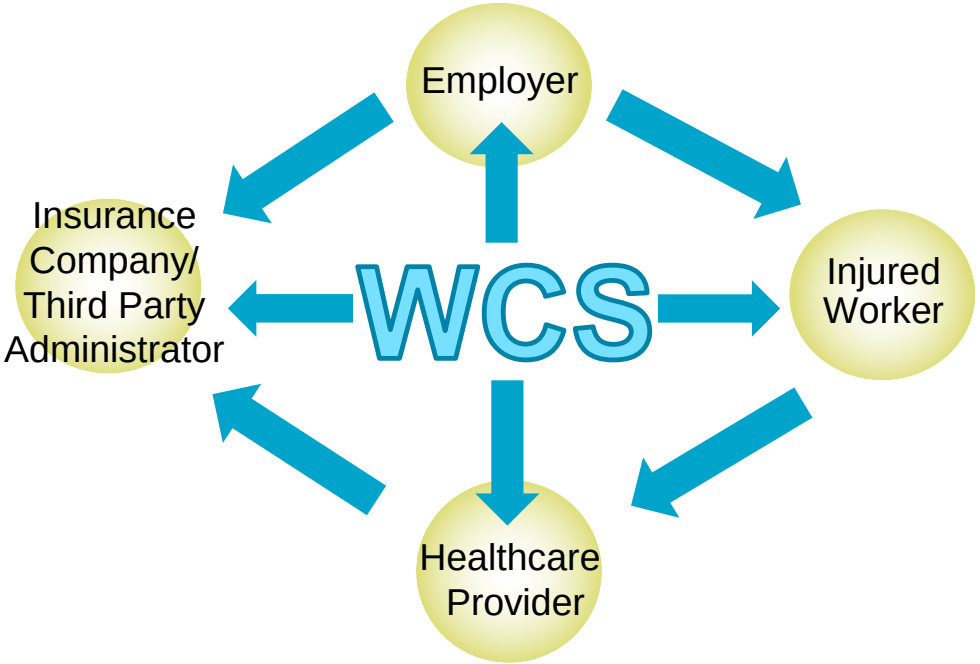
# What is Workers' Compensation?

- No-Fault insurance program
- Provide benefits to injured workers
- Protection for Employers
- Government-mandated program for employers who has one or more employees
- "Exclusive Remedy"

# What is Workers' Compensation?

- WC benefits are effective immediately
- Mandatory Workers' Compensation Insurance Coverage with Approved Carrier, be Self-Insured or join Self-Insured groups.
- Admin fine for uninsured employers
- Pay penalties and/or closed

# The World of Workers' Compensation




The injured worker shall not pay any amount related to his injury.
The healthcare provider may not charge the injured worker.

# WORKERS' COMPENSATION

FORMS

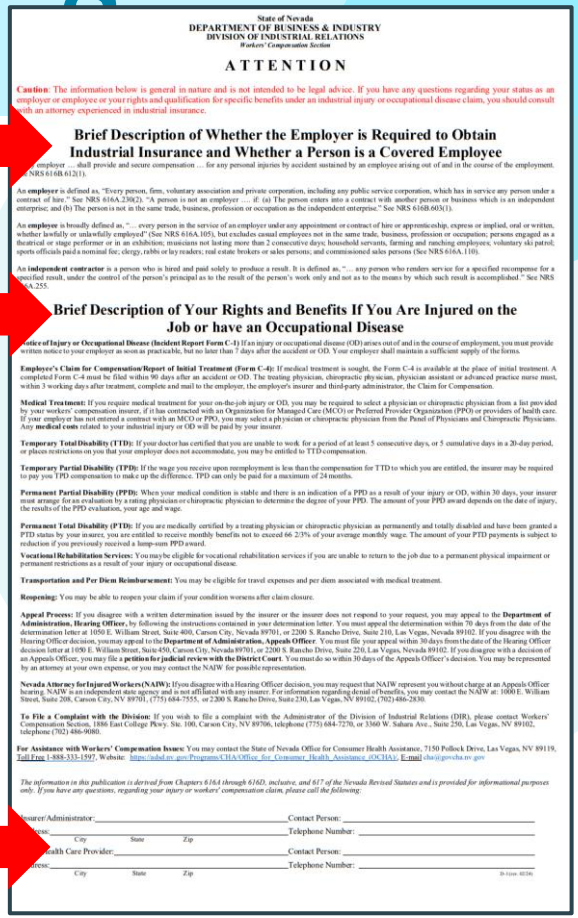
# D-1 Form

## Brief Description of Employee's Rights and Benefits

# Brief Description of Your Rights

## (Form D-1) Pursuant to NRS 616A.490 & NAC 616A.460

- In a common area
- Provided by Insurer/TPA
- Must be posted in proper size (11” X 17”)
- Most Current poster (2/2024)
- The bottom section must be filled out completely



State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
*Workers' Compensation Section*

**ATTENTION**

**Caution**: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

**Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee**

...employer ... shall provide and secure compensation ... for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer .... if: (a) The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "... every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; persons engaged as a theatrical or stage performer or in an exhibition; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "... any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

**Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease**

**Notice of Injury or Occupational Disease (Incident Report Form C-1)** If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

**Employee's Claim for Compensation/Report of Initial Treatment (Form C-4):** If medical treatment is sought, the Form C-4 is available at the place of initial treatment. A completed Form C-4 must be filed within 90 days after an accident or OD. The treating physician, chiropractic physician, physician assistant or advanced practice nurse must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

**Medical Treatment:** If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractic physician from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered a contract with an MCO or PPO, you may select a physician or chiropractic physician from the Panel of Physicians and Chiropractic Physicians. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

**Temporary Total Disability (TTD):** If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

**Temporary Partial Disability (TPD):** If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

**Permanent Partial Disability (PPD):** When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractic physician to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation, your age and wage.

**Permanent Total Disability (PTD):** If you are medically certified by a treating physician or chiropractic physician as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a lump-sum PPD award.

**Vocational Rehabilitation Services:** You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

**Transportation and Per Diem Reimbursement:** You may be eligible for travel expenses and per diem associated with medical treatment.

**Reopening:** You may be able to reopen your claim if your condition worsens after claim closure.

**Appeal Process:** If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeals Officer's decision. You may be represented by an attorney at your own expense, or you may contact the NAIW for possible representation.

**Nevada Attorney for Injured Workers (NAIW):** If you disagree with a Hearing Officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

**To File a Complaint with the Division:** If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 1886 Esst College Pkwy. Ste. 100, Carson City, NV 89706, telephone (775) 684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

**For Assistance with Workers' Compensation Issues:** You may contact the State of Nevada Office for Consumer Health Assistance, 7150 Pollock Drive, Las Vegas, NV 89119, Toll Free 1-888-333-1597. Website: https://adsd.nv.gov/Programs/CHA/Office_for_Consumer_Health_Assistance_(OCHA)/; E-mail cha@govcha.nv.gov

*The information in this publication is derived from Chapters 616A through 616D, inclusive, and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:*

Insurer/Administrator:_____ Contact Person: _____
Address:_____ Telephone Number: _____
City State Zip
Health Care Provider:_____ Contact Person: _____
Address:_____ Telephone Number: _____
City State Zip
D-1(rev. 02/24)

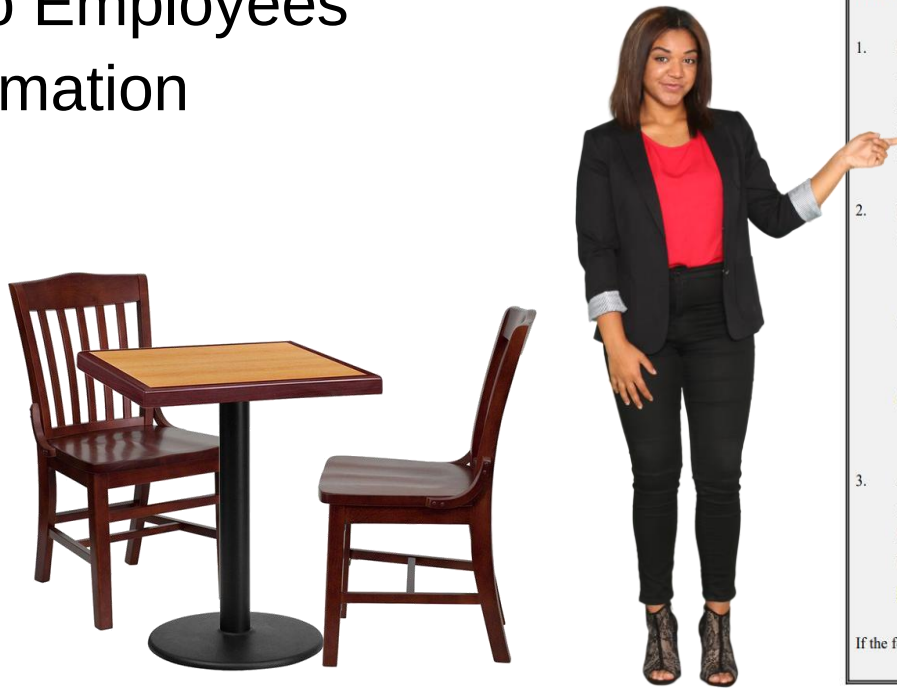
# D-22 Form

Election by Employee to Report Tips

# Notice to Employees re: Tips

## (Form D-22) Pursuant to NAC 616A.470

Notice to Employees
Tip Information



## NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

# C-1 Form

Notice of Injury or Occupational Disease

# Notice of Injury or Occupational Disease (C-1 Form)

## NRS 616C.015

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

| | | |
|---|---|---|
| Name of Employee | Social Security Number | Telephone Number |
| Date of Accident (if applicable) | Time of Accident (if applicable) | Place where accident occurred (if applicable) |
| What is the nature of the injury or occupational disease? | List any body parts involved: | |
| Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment) | | |
| Names of witnesses: | | |
| Did the employee leave work because of the injury or occupational disease? ___ YES ___ NO | If yes, when (date and time)? | Has the employee returned to work? ___ YES ___ NO / If yes, when (date and time)? |
| Was first aid provided? ___ YES ___ NO | If yes, by whom? | Name and address of treating physician, if applicable or known |
| Did the accident happen in the normal course of work? (if applicable) ___ YES ___ NO | | |
| Was anyone else involved? ___ YES ___ NO | Names of others involved | |

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

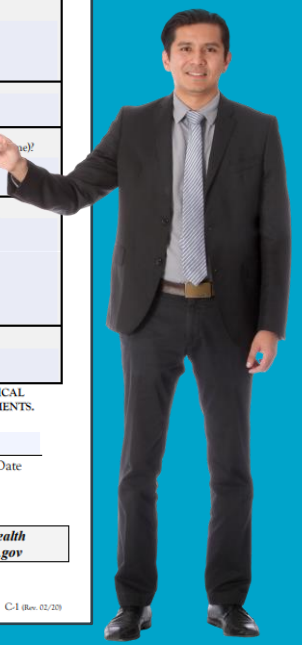
Supervisor's Signature _____ Date _____ Signature of Injured or Disabled Employee _____ Date _____

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

*For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA/ E-mail: cha@govcha.nv.gov*

Employee should sign, date and retain a copy.
*Original to Employer, Copy to Employee*

C-1 (Rev. 02/20)



- Used to report a work injury
- Furnished to employee by employer
- Completed within 7 days of accident by injured employee and signed by both employee and employer

# Notice of Injury or Occupational Disease (C-1 Form)

## NRS 616C.015

- Insurer/TPA should supply forms to employer
- Employer to maintain sufficient supply of blank forms
- Completed forms retained by employer for 3 years
- Use latest version 2/2020

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer _____

| Name of Employee | Social Security Number | Telephone Number |
|---|---|---|
| | | |

| Date of Accident (if applicable) | Time of Accident (if applicable) | Place where accident occurred (if applicable) |
|---|---|---|
| | | |

| What is the nature of the injury or occupational disease? | List any body parts involved: |
|---|---|
| | |

Briefly describe accident or circumstances of occupational disease:
(Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)

Names of witnesses:

| Did the employee leave work because of the injury or occupational disease? ___ YES ___ NO | If yes, when (date and time)? | Has the employee returned to work? ___ YES ___ NO | If yes, when (date and time)? |
|---|---|---|---|
| Was first aid provided? ___ YES ___ NO | If yes, by whom? | Name and address of treating physician, if applicable or known | |
| Did the accident happen in the normal course of work? (if applicable) ___ YES ___ NO | | | |
| Was anyone else involved? ___ YES ___ NO | Names of others involved | | |

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature _____ Date _____ Signature of Injured or Disabled Employee _____ Date _____

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*For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA/ E-mail: cha@govcha.nv.gov*

Employee should sign, date and retain a copy.
***Original to Employer, Copy to Employee***

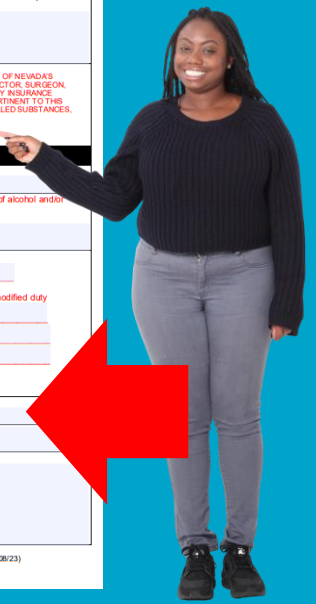
C-1 (Rev. 02/20)

# C-4 Form

Employee's Claim for Compensation Form

# Employee's Claim for Compensation/ Report of Initial Treatment (C-4 Form)

## NRS 616C.040



- Documents the initial medical treatment of the injured worker
- Upper portion to be completed by employee and lower portion by the medical provider
- Injured worker has 90 days to seek medical treatment
- Don't forget to get the injured worker's signature!

**EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT**
**FORM C-4**
PLEASE TYPE OR PRINT

**EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED**

First Name | M.I. | Last Name | Birthdate | Sex ☐M ☐F | Claim Number (Insurer's Use Only)

Home Address | Age | Height | Weight | Social Security Number

City | State | Zip | Telephone

Mailing Address | City | State | Zip | Primary Language Spoken

INSURER | THIRD-PARTY ADMINISTRATOR | Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name | Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable) | Hours Injury (if applicable) am pm | Date Employer Notified | Last Day of Work After Injury or Occupational Disease | Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? | Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease | Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERAN ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date | Place | Employee's Original or Electronic Signature

**THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT**

Place | Name of Facility

Date / Hour | Diagnosis and Description of Injury or Occupational Disease

Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?
☐ No ☐ Yes (if yes, please explain)

Treatment:

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty
If modified duty, specify any limitations/restrictions: _____

X-Ray Findings:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?
☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date | Print Health Care Provider's Name | I certify that the employer's copy of this form was delivered to the employer on:

Address | INSURER'S USE ONLY

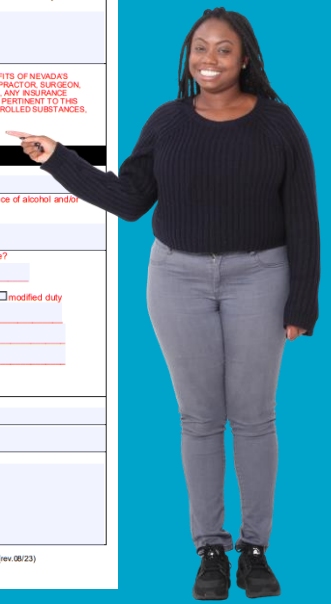
City | State | Zip | Provider's Tax I.D. Number | Telephone

Health Care Provider's Original or Electronic Signature | Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.08/23)

# Employee's Claim for Compensation/ Report of Initial Treatment (C-4 Form)

## NRS 616C.040



- Medical provider has 3 working days to complete, and mail to the CORRECT Insurer/Third Party Administrator (TPA) and to the employer
- Medical provider to maintain sufficient supply

**EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT**
**FORM C-4**
PLEASE TYPE OR PRINT

**EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED**

First Name | M.I. | Last Name | Birthdate | Sex ☐M ☐F | Claim Number (Insurer's Use Only)

Home Address | Age | Height | Weight | Social Security Number

City | State | Zip | Telephone

Mailing Address | City | State | Zip | Primary Language Spoken

**INSURER** | **THIRD-PARTY ADMINISTRATOR** | Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name | Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable) | Hours Injury (if applicable) am pm | Date Employer Notified | Last Day of Work After Injury or Occupational Disease | Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? | Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease | Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERAN ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date | Place | Employee's Original or Electronic Signature

**THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT**

Place | Name of Facility

Date / Hour | Diagnosis and Description of Injury or Occupational Disease

Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?
☐ No ☐ Yes (if yes, please explain)

Treatment:

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty
If modified duty, specify any limitations/restrictions: _____

X-Ray Findings:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?
☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date | Print Health Care Provider's Name | I certify that the employer's copy of this form was delivered to the employer on:

Address | INSURER'S USE ONLY

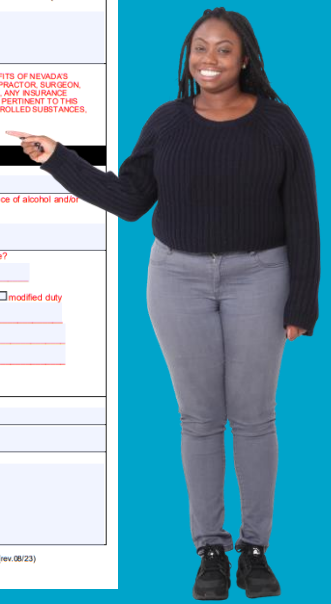
City | State | Zip | Provider's Tax I.D. Number | Telephone

Health Care Provider's Original or Electronic Signature | Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.08/23)

# Employee's Claim for Compensation/ Report of Initial Treatment (Form C-4)

## NRS 616C.040 (7)



- The Administrator may impose an administrative fine of not more than $1,000 for each violation of subsection 1 on a treating physician, chiropractic physician, physician assistant or advanced practice registered nurse for not sending the C-4 Form in a timely manner
- Use latest version (8/2023)

**EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT**
**FORM C-4**
PLEASE TYPE OR PRINT

**EMPLOYEE'S CLAIM PROVIDE ALL INFORMATION REQUESTED**

First Name | M.I. | Last Name | Birthdate | Sex ☐M ☐F | Claim Number (Insurer's Use Only)

Home Address | Age | Height | Weight | Social Security Number

City | State | Zip | Telephone

Mailing Address | City | State | Zip | Primary Language Spoken

**INSURER** | **THIRD-PARTY ADMINISTRATOR** | Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name | Telephone

Office Mail Address (Number and Street)

Date of Injury (if applicable) | Hours Injury (if applicable) am pm | Date Employer Notified | Last Day of Work After Injury or Occupational Disease | Supervisor to Whom Injury Reported

Address or Location of Accident (if applicable)

What were you doing at the time of the accident? (if applicable)

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment? | Witnesses to the Accident (if applicable)

Nature of Injury or Occupational Disease | Part(s) of Body Injured or Affected

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE, OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER OR ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERAN ADMINISTRATION OR GOVERNMENTAL HOSPITAL, ANY MEDICAL SERVICE ORGANIZATION, ANY INSURANCE COMPANY, OR OTHER INSTITUTION OR ORGANIZATION TO RELEASE TO EACH OTHER, ANY MEDICAL OR OTHER INFORMATION, INCLUDING BENEFITS PAID OR PAYABLE, PERTINENT TO THIS INJURY OR DISEASE, EXCEPT INFORMATION RELATIVE TO DIAGNOSIS, TREATMENT AND/OR COUNSELING FOR AIDS, PSYCHOLOGICAL CONDITIONS, ALCOHOL OR CONTROLLED SUBSTANCES, FOR WHICH I MUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

Date | Place | Employee's Original or Electronic Signature

**THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT**

Place | Name of Facility

Date / Hour | Diagnosis and Description of Injury or Occupational Disease

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☐ No ☐ Yes (if yes, please explain)

Treatment:

Have you advised the patient to remain off work five days or more?
☐ Yes Indicate dates: from _____ to _____
☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty

X-Ray Findings:

If modified duty, specify any limitations/restrictions: _____

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?
☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date | Print Health Care Provider's Name | I certify that the employer's copy of this form was delivered to the employer on:

Address | INSURER'S USE ONLY

City | State | Zip | Provider's Tax I.D. Number | Telephone

Health Care Provider's Original or Electronic Signature | Degree (MD, DO, DC, PA-C, APRN) Choose (if applicable)

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.08/23)

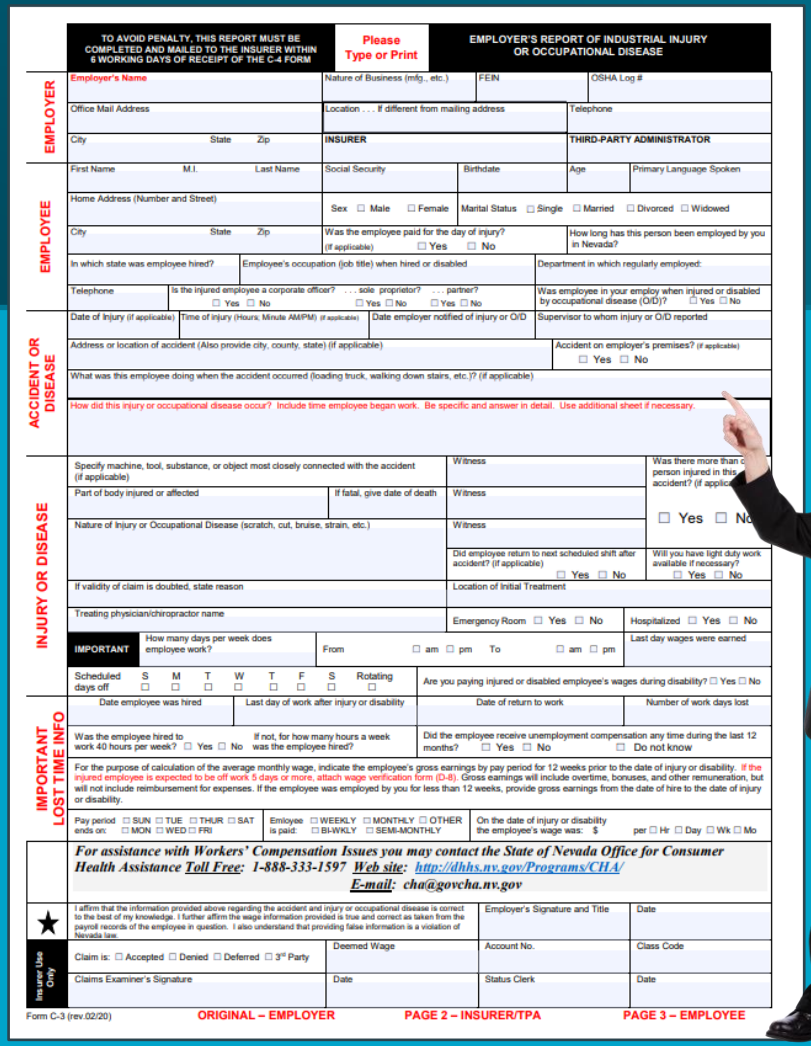
# C-3 Form

## Employer's Report of Industrial Injury or Occupational Disease

# Employer's Report of Industrial Injury or Occupational Disease
## (C-3 Form)

## NRS 616C.045

- Completed by employer upon receipt of a C-4 Form
- Completed and signed by employer or designee in its entirety
- Employer has 6 working days to complete Form C-3 and mail to Insurer/TPA
- Max fine of $1,000 per occurrence.
- Use latest version (2/2020)



TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name | Nature of Business (mfg., etc.) | FEIN | OSHA Log #

Office Mail Address | Location . . . If different from mailing address | Telephone

City State Zip | INSURER | THIRD-PARTY ADMINISTRATOR

EMPLOYEE

First Name M.I. Last Name | Social Security | Birthdate | Age | Primary Language Spoken

Home Address (Number and Street) | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

City State Zip | Was the employee paid for the day of injury? (if applicable) ☐ Yes ☐ No | How long has this person been employed by you in Nevada?

In which state was employee hired? | Employee's occupation (job title) when hired or disabled | Department in which regularly employed:

Telephone | Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No | Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable) | Time of injury (Hours; Minute AM/PM) (if applicable) | Date employer notified of injury or O/D | Supervisor to whom injury or O/D reported

Address or location of accident (Also provide city, county, state) (if applicable) | Accident on employer's premises? (if applicable) ☐ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable) | Witness | Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No

Part of body injured or affected | If fatal, give date of death | Witness

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.) | Witness

Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☐ No | Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason | Location of Initial Treatment

Treating physician/chiropractor name | Emergency Room ☐ Yes ☐ No | Hospitalized ☐ Yes ☐ No

IMPORTANT | How many days per week does employee work? | From ☐ am ☐ pm To ☐ am ☐ pm | Last day wages were earned

Scheduled days off S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐ | Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired | Last day of work after injury or disability | Date of return to work | Number of work days lost

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No | If not, for how many hours a week was the employee hired? | Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI | Employee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY | On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

*For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA/ E-mail: cha@govcha.nv.gov*

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law. | Employer's Signature and Title | Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party | Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

Form C-3 (rev.02/20) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

# D-8 Form

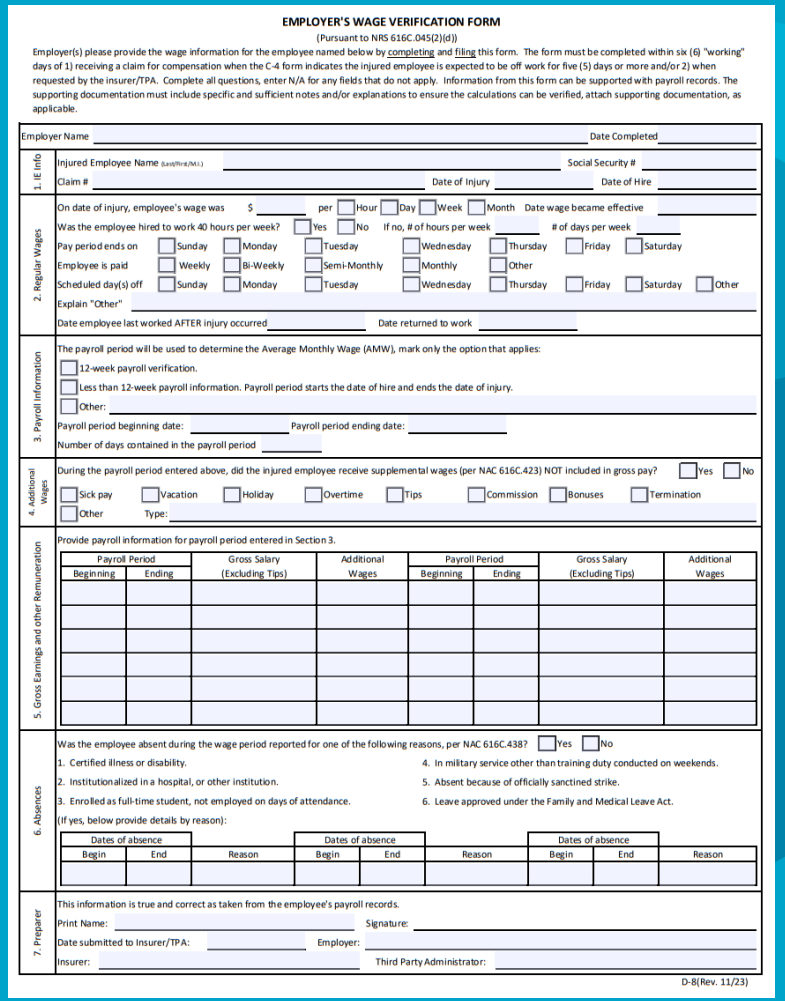
Employer's Wage Verification Form

# Employer's Wage Verification Form

## (D-8 Form)

## NRS 616C.420

- Completed by employer to calculate the injured worker's benefit
- Must be completed if injured worker is off work for 5 days or more per the C-4 Form
- Furnished by employer to the Insurer/Third Party Administrator (TPA) within 6 working days of receipt of the C-4 form.



**EMPLOYER'S WAGE VERIFICATION FORM**

(Pursuant to NRS 616C.045(2)(d))

Employer(s) please provide the wage information for the employee named below by completing and filing this form. The form must be completed within six (6) "working" days of 1) receiving a claim for compensation when the C-4 form indicates the injured employee is expected to be off work for five (5) days or more and/or 2) when requested by the insurer/TPA. Complete all questions, enter N/A for any fields that do not apply. Information from this form can be supported with payroll records. The supporting documentation must include specific and sufficient notes and/or explanations to ensure the calculations can be verified, attach supporting documentation, as applicable.

Employer Name _____ Date Completed _____

1. IE Info

Injured Employee Name (Last/First/M.I.) _____ Social Security # _____

Claim # _____ Date of Injury _____ Date of Hire _____

2. Regular Wages

On date of injury, employee's wage was $ _____ per ☐ Hour ☐ Day ☐ Week ☐ Month Date wage became effective _____

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No If no, # of hours per week _____ # of days per week _____

Pay period ends on ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Employee is paid ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other

Scheduled day(s) off ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Other

Explain "Other" _____

Date employee last worked AFTER injury occurred _____ Date returned to work _____

3. Payroll Information

The payroll period will be used to determine the Average Monthly Wage (AMW), mark only the option that applies:

☐ 12-week payroll verification.

☐ Less than 12-week payroll information. Payroll period starts the date of hire and ends the date of injury.

☐ Other: _____

Payroll period beginning date: _____ Payroll period ending date: _____

Number of days contained in the payroll period _____

4. Additional Wages

During the payroll period entered above, did the injured employee receive supplemental wages (per NAC 616C.423) NOT included in gross pay? ☐ Yes ☐ No

☐ Sick pay ☐ Vacation ☐ Holiday ☐ Overtime ☐ Tips ☐ Commission ☐ Bonuses ☐ Termination

☐ Other Type: _____

5. Gross Earnings and other Remuneration

Provide payroll information for payroll period entered in Section 3.

| Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Additional Wages | Payroll Period Beginning | Payroll Period Ending | Gross Salary (Excluding Tips) | Additional Wages |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

6. Absences

Was the employee absent during the wage period reported for one of the following reasons, per NAC 616C.438? ☐ Yes ☐ No

1. Certified illness or disability.
2. Institutionalized in a hospital, or other institution.
3. Enrolled as full-time student, not employed on days of attendance.
4. In military service other than training duty conducted on weekends.
5. Absent because of officially sanctined strike.
6. Leave approved under the Family and Medical Leave Act.

(If yes, below provide details by reason):

| Dates of absence Begin | Dates of absence End | Reason | Dates of absence Begin | Dates of absence End | Reason | Dates of absence Begin | Dates of absence End | Reason |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

7. Preparer

This information is true and correct as taken from the employee's payroll records.

Print Name: _____ Signature: _____

Date submitted to Insurer/TPA: _____ Employer: _____

Insurer: _____ Third Party Administrator: _____

D-8(Rev. 11/23)

# Employer Responsibilities

## Provide information to ALL employees:

- Policies/Procedures in reporting a work injury, including the forms required in the State of Nevada
- Complete name of the Employer or DBA and complete office address and telephone number
- Name of WC Insurer and contact information, TPA if they have one.
- Where to go for medical treatment
- Managed Care Organization (MCO) if available
- Provide Notice of Injury or Occupational Disease (C-1 Form)
- Accommodation process (If light duty is available)

# More Employer Responsibilities

- **Provide a safe work environment**
- Contract with a registered Nevada Workers Comp insurance company. Know your TPA if there is one.
- Fill out Employers Report of Industrial Injury or Occupational Disease (C-3 Form) within 6 days after the receipt of a C-4 Form and submit to insurer/TPA
- Report orally to NV OSHA any accidents resulting in fatality or fatalities within 8 hours of incident
- Report orally within 24 hours to NVOSHA any accidents resulting in inpatient hospitalization, amputation of a body part or loss of an eye
- To report an incident to NVOSHA, call (702) 486-9020 (Southern Nevada) or (775) 688-3700 (Northern Nevada)

# More Employer Information

**Insurers have 30 days after accident notification (or 30 working days after claim receipt for occupational disease):**

- Accept the claim & notify claimant or claimant's rep of acceptance
- Begin payment on the claim
- Or deny the claim and notify claimant or claimant's rep and DIR of denial
- Insurer's notification must be documented with a certificate of mailing.

# More Employer Information

**What type of Workers' Compensation benefits are employees entitled to? These benefits may include (among others):**

- Medical treatment
- Lost time compensation (Temporary Total Disability/Temporary Partial Disability)
- Permanent Partial Disability (PPD)
- Permanent Total Disability (PTD)
- Vocational Rehabilitation
- Dependent's benefits in the event of death
- Other claims-related benefits or expenses (e.g., mileage)

# More Employer Information

**Must an injured worker accept the offer of a light duty job?**

An injured worker who rejects a light duty offer made in accordance with NRS 616C.475 and NAC 616C.583 risks the discontinuation of temporary total disability compensation.

**Are undocumented alien workers covered under Nevada's workers' comp statutes?**

Yes. According to NRS 616A.105, "employee and worker are used interchangeably … and mean every person in the service of an employer … whether lawfully or unlawfully employed" including "aliens." However, undocumented alien workers are not eligible for vocational rehabilitation.

# The State of Nevada Workers' Compensation Regulatory and Enforcement Team


State of Nevada

Nevada Department of Business and Industry

Division of Industrial Relations (DIR)

**Workers' Compensation Section**

OSHA

SCATS

MECH

MINE

LEGAL

Medical Unit

Enforcement Unit (Employer Compliance)

Audit Unit

Education, Research and Analysis Unit

Insurance Compliance Unit

Workers' Compensation Section

# Medical Unit

The MU assists in:

- Insurance coverage verification
- D-35 processing
- Maintenance of the Treating and Rating panels of WC physicians
- Medical bill appeal
- Investigate C-4 Violations
- HCP, insurer, TPA, employers and injured employee complaints

Workers' Compensation Section

# Enforcement Unit

The Enforcement Unit (also known as ECU - Employer Compliance Unit):

- Responsible for ensuring that employers comply with the mandatory coverage provisions.
- Conduct employer site visits and the employer must provide evidence of coverage in compliance with NRS 616A.495.
- If an employer fails to provide or maintain coverage for workers' compensation, then an order to cease business operations will be issued in accordance with NRS 616D.110.
- Uninsured Employer Investigations

Workers' Compensation Section

# Audit Unit

The Audit Unit conducts:

- Audit of each Workers' Comp insurer at least every five years
- Investigation of complaints filed by injured workers against employers, healthcare providers, insurers and third-party administrators (TPA)
- Address injured workers' questions and concerns via email, phone calls and walk ins
- Reviews and make recommendations on all TPA applications

Workers' Compensation Section

# Education, Research and Analysis Unit

The E,R&A Unit is responsible for:

- Educational Outreach (Website, Emails, Educational Conference)
- Claims Indexing (D-38)
- Debt Collection (Fines and Penalties)
- Data Collection and Compilation (Annual Claims Activity Report, OD-8s)
- CARDS Management and Support
- Special Projects (DIR's regulations and research)

Workers' Compensation Section

# Insurer Compliance Unit

Insurer Compliance Unit conducts:

- Investigations of complaints that could result in a Benefit Penalty
- Investigation of compliance with HO/AO decisions
- Uninsured Claims Administration
- Subsequent Injury Account – Reimbursement requests
- Cost of Living Adjustment (COLA) Reimbursements

# Uninsured Employer Consequences

Employers who fail to secure and maintain a workers' compensation policy for their employees will be charged with an administrative fine up to $15,000.

Employers will pay a premium penalty for the time the employer was uninsured.

Employers will be held financially responsible for all costs relating to an uninsured claim.

Possible criminal prosecution from the Attorney General's Office.

# WORKER MISCLASSIFICATION

- Employer Misclassification of workers is a growing problem.
- Worker Misclassification occurs when employers misclassify their employees as “independent contractors” in order to eliminate the employer/employee relationship.
- A 1099 or contract does not always eliminate the employer/employee relationship
- Employers must examine their employment relationships before deeming their employees as “independent contractors”

# WORKER MISCLASSIFICATION

NRS 616B.603 pertains to Independent Enterprises and should be considered to determine if you could be deemed an employer under this provision.

In order to not be deemed the employer under the “independent enterprise exemption,”

1) You must not be “in the same trade, business, profession or occupation” as the person or business with whom you contract, and

2) The person or business with whom you contract must be an independent enterprise. Otherwise, workers’ compensation coverage is required.

Incorrectly deeming employees as independent contractors can lead to serious consequences.

# WORKERS' COMPENSATION

## Myths and Realities

**Myth:** Family and/or part-time employees do not require coverage

**Reality:** WC coverage is required

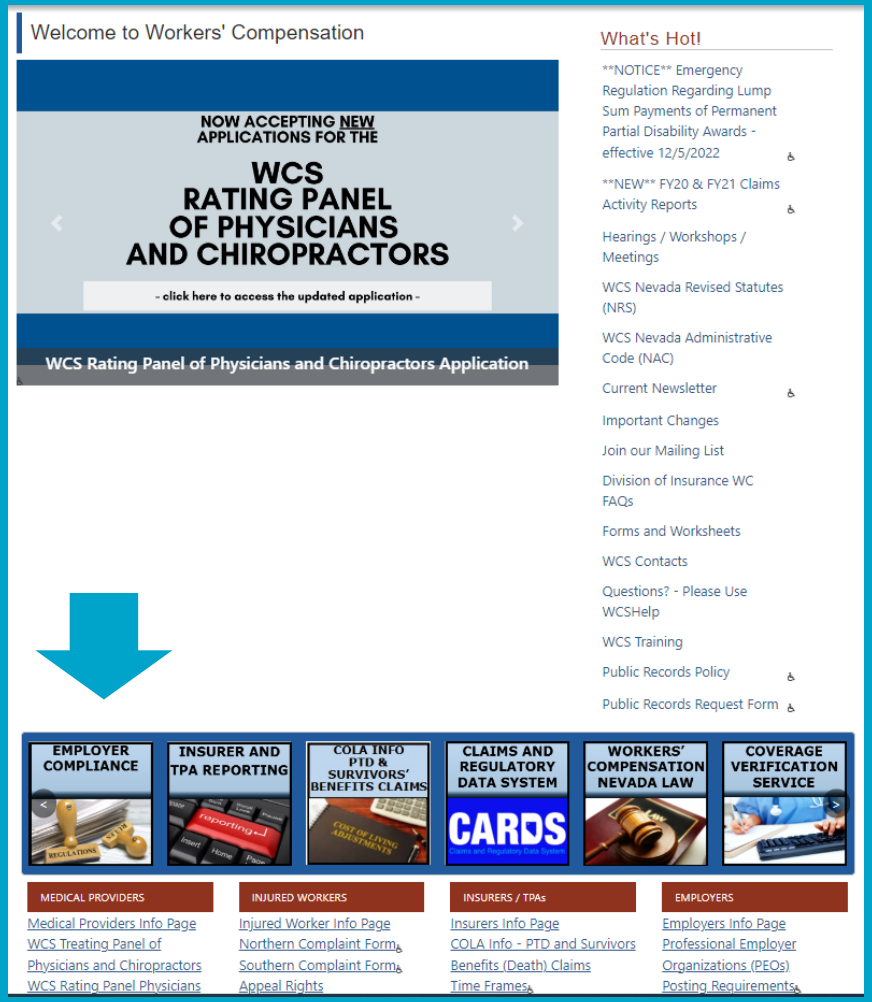
# WORKERS' COMPENSATION

## Myths and Realities

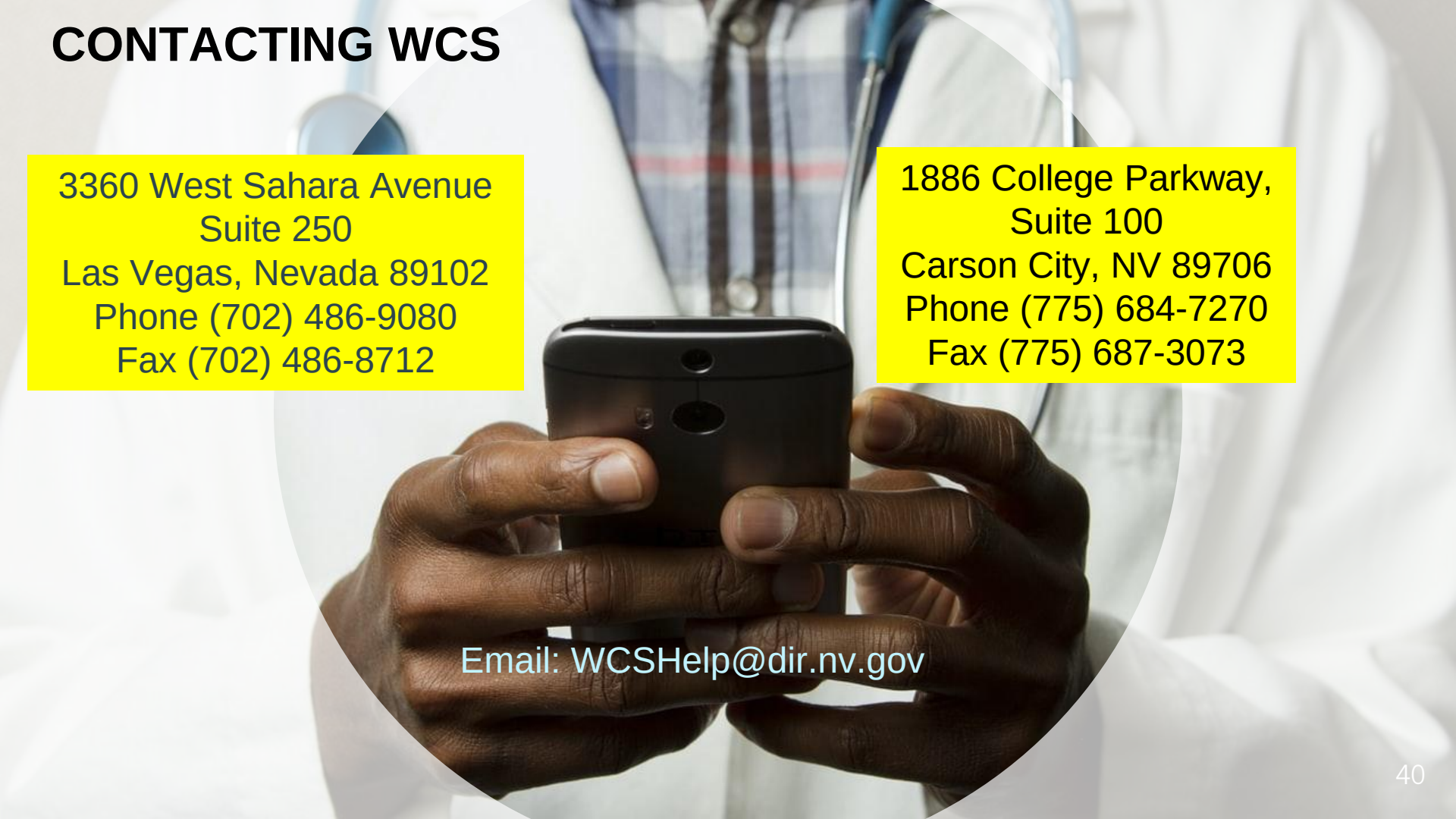
**Myth:** The subcontractors that I hire should have their own coverage, so I won't worry about workers' compensation insurance.

**Reality:** If you are a licensed contractor, you should know that you may be determined to be the employer of independent contractors, subcontractors and their employees for purposes of providing workers compensation insurance coverage.

# WCS Website


Welcome to Workers' Compensation
NOW ACCEPTING NEW APPLICATIONS FOR THE
WCS RATING PANEL OF PHYSICIANS AND CHIROPRACTORS
- click here to access the updated application -
WCS Rating Panel of Physicians and Chiropractors Application
What's Hot!
**NOTICE** Emergency Regulation Regarding Lump Sum Payments of Permanent Partial Disability Awards - effective 12/5/2022
**NEW** FY20 & FY21 Claims Activity Reports
Hearings / Workshops / Meetings
WCS Nevada Revised Statutes (NRS)
WCS Nevada Administrative Code (NAC)
Current Newsletter
Important Changes
Join our Mailing List
Division of Insurance WC FAQs
Forms and Worksheets
WCS Contacts
Questions? - Please Use WCSHelp
WCS Training
Public Records Policy
Public Records Request Form
EMPLOYER COMPLIANCE
INSURER AND TPA REPORTING
COLA INFO PTD & SURVIVORS' BENEFITS CLAIMS
CLAIMS AND REGULATORY DATA SYSTEM
CARDS
WORKERS' COMPENSATION NEVADA LAW
COVERAGE VERIFICATION SERVICE
MEDICAL PROVIDERS
Medical Providers Info Page
WCS Treating Panel of Physicians and Chiropractors
WCS Rating Panel Physicians
INJURED WORKERS
Injured Worker Info Page
Northern Complaint Form
Southern Complaint Form
Appeal Rights
INSURERS / TPAs
Insurers Info Page
COLA Info - PTD and Survivors Benefits (Death) Claims
Time Frames
EMPLOYERS
Employers Info Page
Professional Employer Organizations (PEOs)
Posting Requirements

# CONTACTING WCS



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Fax (702) 486-8712

1886 College Parkway,
Suite 100
Carson City, NV 89706
Phone (775) 684-7270
Fax (775) 687-3073

Email: WCSHelp@dir.nv.gov

Thank you for visiting our website. Please check out our website for upcoming Workers' Comp-related training video.