



State of Nevada
Division of Industrial Relations
Workers' Compensation
&
Nevada Employers

WORKERS' COMPENSATION SECTION

WCS 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**

Why Workers' Compensation?

- **No-Fault**
 - **Benefits to Employees**
 - **Protection for Employers**
- **“Exclusive Remedy”**
- **Mandatory Workers' Compensation Insurance Coverage with Approved Carrier**



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

- Must be posted in proper size (11" X 17")
- Most Current poster (10/20)
- Provided by Insurer/TPA
- 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

Every 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 616A.012(1).

An employer is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has a 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 616A.010(3).

An employee is legally 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 verbally or unlawfully employed" (See NRS 616A.100), but excludes casual employees not in the same trade, business, profession or occupation; mechanics not having more than 2 consecutive days household services, farming and ranching employees; voluntary-act period; sports officials paid a nominal fee; clergy, rabbi or lay readers; and estate trustees 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 services for a specified response 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 (Section 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 5 days after the accident or OD. Your employer shall maintain a sufficient supply of the form.

Claim for Compensation (Form C-4) If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor 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 chiropractor from a list provided by your workers' compensation insurer. If you are insured with an **Organization for Managed Care (OMC)** or Preferred Provider Organization (PPO) or provision of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. 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 if less restrictions on your job 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 treating physician or chiropractor 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 and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor 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 payment is subject to reduction if you previously received a 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.

Resting: 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 2300 S. Rardin 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 400, Carson City, Nevada 89701, or 2300 S. Rardin Drive, Suite 210, 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 NAW 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 more information or for a trial of benefits, you may contact the NAIW at 1800 L. William Street, Suite 200, Carson City, NV 89701, (775) 684-7455, or 2300 S. Rardin Drive, Suite 210, Las Vegas, NV 89102, (702) 486-2630.

To File a Complaint with the Division: If you wish to file a complaint with the **Administrative Division of Industrial Relations (DIR)**, please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7230, or 3366 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101. Toll Free: 1-888-333-1597. Web site: <http://govcha.state.nv.us>. E-mail: cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A 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: _____ City _____ State _____ Zip _____ Telephone Number: _____
MCO/Health Care Provider _____ Contact Person: _____
Address: _____ City _____ State _____ Zip _____ Telephone Number: _____

04/10/10 11/10

Employer Posting Requirements

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Form D-22 Notice to Employees Tip Information (NAC 616A.470)

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.

Other Employer Requirements

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- **Information to Employees**
 - **Policies/Procedures**
 - **Who is Employer/Insurer**
 - **Where to go for treatment/Managed Care Organization (MCO)/Preferred Provider Organization (PPO)**
 - **Notice of Injury or Occupational Disease (Form C-1)**
 - **Employers Report of Industrial Injury or Occupational Disease (Form C-3)**

Employee's Claim For Compensation/Report Of Initial Treatment - Form C-4

- **NRS 616C.040**
- **Completed by employee and medical provider**
- **Employee has 90 days to seek treatment**
- **Medical provider has 3 working days**
 - **to complete, and**
 - **mail to employer and CORRECT Insurer/Third Party Administrator (TPA)**
- **Furnished by medical provider (Workers' Compensation Section website)**
- **Medical provider to maintain sufficient supply
Physician/Chiropractor fined - per violation (Max \$1000)**

Employer's Report Of Industrial Injury Or Occupational Disease – Form C-3

➤ NRS 616C.045

➤ Furnished to employer by Insurer/Third Party Administrator (TPA) Completed by employer in its entirety

➤ Upon receipt of Form C-4, employer has 6 working days to complete and mail to Insurer/TPA

➤ Copy to Employee from the Employer

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 (mtg., 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
	City State Zip	Was the employee paid for the day of injury? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
ACCIDENT OR DISEASE	Telephone	Is the injured employee a corporate officer? ... sole proprietor? ... partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		Was employee in your employ when injured or disabled by occupational disease (OD)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	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) <input type="checkbox"/> Yes <input type="checkbox"/> 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)		
	Part of body injured or affected	If fatal, give date of death	Witness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	Did employee return to next scheduled shift after accident? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No		
	If validity of claim is doubted, state reason		Location of Initial Treatment		
Treating physician/ chiropractor name	Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	Last day wages were earned		
IMPORTANT	How many days per week does employee work?	From <input type="checkbox"/> am <input type="checkbox"/> pm To <input type="checkbox"/> am <input type="checkbox"/> pm			
IMPORTANT LOST TIME INFO	Scheduled days off	S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S <input type="checkbox"/> Rotating <input type="checkbox"/>	Are you paying injured or disabled employee's wages during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 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 (C-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 <input type="checkbox"/> SUN <input type="checkbox"/> TUE <input type="checkbox"/> THUR <input type="checkbox"/> SAT ends on: <input type="checkbox"/> MON <input type="checkbox"/> WED <input type="checkbox"/> FRI		Employee is paid: <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER <input type="checkbox"/> BIWEEKLY <input type="checkbox"/> SEMI-MONTHLY	On the date of injury or disability, the employee's wage was: \$ _____ per <input type="checkbox"/> Hr <input type="checkbox"/> Day <input type="checkbox"/> Wk <input type="checkbox"/> Mo		
For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://govcha.state.nv.us E-mail: cha@govcha.state.nv.us					
Insurer/TPA Only	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	
	Claim is: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> 3 rd Party	Deemed Wage	Account No.	Class Code	
	Claims Examiner's Signature	Date	Status Clerk	Date	

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

Employer Compliance Unit

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- **Employer Compliance Investigations**
- **Cancellation/Lapse Investigations**
- **Uninsured Claim Investigations**
 - **The uninsured injured worker may choose:**
 - Assign to Uninsured Claims Account**
 - Employee Election for Compensation (Form D-16)**
 - Employee's Claim for Compensation (D-17)**

Employer Compliance Unit

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- **If Coverage Lapse/No Coverage**
 - **Issue Administrative Fines**
 - **Premium Penalties**
 - **Order to pay missed premiums from uncovered period**
 - **Order Closure of Business**

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

Myth: The subs 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.

Note: If an employee of a subcontractor or an independent contractor has a work-related injury and the employer has not secured industrial insurance, the principal contractor will be responsible for the actual cost of the claim, plus administrative fees.



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.

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

Possible criminal prosecution from the Attorney General's Office



WCS Website

<http://dir.nv.gov/WCS/home/>

State of Nevada Department of Business & Industry
Industrial Relations (DIR)

Agencies Jobs Feedback

Google Custom Search

Search This Site Search All Sites

ADA Assistance PRINT

HOME LABOR STATS MECHANICAL MINES OSHA SCATS WORKERS' COMP CONTACT

WELCOME TO WORKERS' COMPENSATION

MILEAGE
Rate Change
Effective January 1, 2019

What's Hot!

- Hearings / Workshops / Meetings
- Current Newsletter &
- Training
- Important Changes
- Join our Mailing List
- Adopted Amendment of NAC 616C.502 and Repeal of NAC 616C.498 (LCB File No. R127-17) &
- Forms and Worksheets
- WCS Contacts
- Questions? - Please Use WCSHelp

COVERED VERIFICATION SERVICE

INJURED WORKERS

EMPLOYER COMPLIANCE

WORKERS' COMPENSATION NEVADA LAW

INSURER AND TPA REPORTING

CLAIMS AND REGULATORY DATA SYSTEM

CARDS

MEDICAL UNIT

- Current Rating Panel &
- Current Treating Panel &
- 2019 Medical Fee Schedule &
- D-35 Form &
- The Pulse Medical Unit Newsletters

INJURED WORKERS

- Northern Complaint Form &
- Southern Complaint Form &
- Appeal Rights
- Claim Reopening
- Nevada Attorney for Injured Workers

INSURERS / TPAS

- Time Frames &
- Standard Audit Requirements &
- Subsequent Injury Accounts
- CARDS Brochure &
- Claims Indexing (D-38) Brochure &

EMPLOYERS

- Employee Leasing Company (PEO)
- Posting Requirements &
- SilverFlume
- Uninsured Employers &

Employer Coverage Requirements

Post Requirements

Employer Information Page

Subsequent Injury Info

Join WCS Email List

Helpful Newsletter

Coverage Verification

Coverage Verification Service



Employer	FEIN
State * Nevada	Coverage Date * 12/23/2019
Employer Name *	<input checked="" type="radio"/> Contains <input type="radio"/> Starts With
<input type="button" value="SEARCH"/>	<input type="button" value="CLEAR"/>

Limitation of Information

The information provided on this web page is a segment of policy information reported to the Nevada Division of Industrial Relations, Workers' Compensation Section by private workers' compensation insurance carriers. Reporting delays, inaccuracies and omissions may affect the reliability of the coverage information provided. Self-insured employers and associations of self-insured employers are not included in the data.

Other Helpful Links

[Nevada Division of Industrial Relations, Workers' Compensation Section](#)

[Nevada Division of Insurance - Self-Insured](#)

[Doing Business as ... "My Nevada" State Portal Business Licenses.](#)

Contacting WCS

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