

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

Reset Form
Print Form

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER section: Employer's Name, Nature of Business (mfg, etc.), FEIN, OSHA Log Number, Office Mail, Location, Telephone Number, City, State, Zip Code, INSURER, THIRD PARTY ADMINISTRATOR

EMPLOYEE section: First Name, M.I., Last Name, Social Security, Birthdate, Age, Primary Language Spoken, Home Address, Sex, Marital Status, City, State, Zip, Was the employee paid for the day of injury?, How long has this person been employed by you in Nevada?, In which state was employee hired?, Employee's occupation, Department in which regularly employed, Telephone, Is the injured employee a corporate officer?, Was employee in your employ when injured or disabled by occupational disease (O/D)?

ACCIDENT OR DISEASE section: Date of Injury, Time of injury, Date employer notified, Supervisor to whom injury or O/D reported, Address or location of accident, Accident on employer's premises?, What was this employee doing when the accident occurred?, How did this injury or occupational disease occur?

INJURY OR DISEASE section: Specify machine, tool, substance, or object most closely connected with the accident, Witness, Part of body injured or affected, If fatal, give date of death, Witness, Nature of Injury or Occupational Disease, Witness, If validity of claim is doubted, state reason, Location of Initial Treatment, Treating physician/chiropractor name, Emergency Room?, Hospitalized?

IMPORTANT LOST TIME INFO section: How many days per week does employee work?, From, to, Last day wages were earned, Scheduled Days Off, Are you paying injured or disabled employee's wages during disability?, 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?, If no, for how many hours a week was the employee hired?, Did the employee receive unemployment compensation any time during the last 12 months?, For the purpose of calculation of the average monthly wage, indicate the employee's gross earning by pay period for 12 weeks prior to the date of injury or disability.

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

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 section: Claim is: Deemed Wage, Account No., Class Code, Claims Examiner's Signature, Date, Status Clerk, Date