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)
Mailing Address	Age / Height	Weight	Social Security Number
City State Zip		Telephone	
Email Address			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 AUTHROIZATION 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)