Print Form

Reset Form

"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 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 of which the employee first became aware of the connection between the condition and employment)

Name 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? ☐ Yes ☐ No

Was anyone else involved? ☐ Yes ☐ No

Names of other involved:

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGES 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.state.nv.us

Employee should sign, date and retain a copy of this form.

Original to Employer, Copy to Employee

C-1 (Rev. 02/20)