# "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? | If yes, when (date and time)? | Has the employee returned to work? | If yes, when (date and time)? |
|---|---|---|---|
| ____ YES<br>____ NO | | ____ YES<br>____ NO | |

| Was first aid provided? | If yes, by whom? | Name and address of treating physician, if applicable or known |
|---|---|---|
| ____ YES<br>____ NO | | |

| Did the accident happen in the normal course of work? (if applicable) |
|---|
| ____ YES<br>____ NO |

| Was anyone else involved? | Names of others involved |
|---|---|
| ____ YES<br>____ NO | |

**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 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***

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