"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer

Name of Employee	Employee ID Number	Phone Number

Date of accident (if applicable)	Time of accident (if applicable)	Location of accident (if applicable)

What is the nature of the injury or occupational disease?	List any body parts involved

Briefly describe the accident or circumstances of occupational disease. Note -If you are claiming occupational disease note the date the employee first became aware of connection between condition and employment.

Name of witnesses

Did the employee leave work because of the injury or occupational disease? ___ Yes ___ No	If yes, time and date	Has the employee returned to work? ___ YES ___ NO	If yes, time and date
Was first aid provided? ___ YES ___ NO	If yes, by whom?	Name of treating physician if applicable or known	
Did the accident happen in the normal course of work? (if applicable) ___ YES ___ NO			
Was anyone else involved? ___ YES ___ NO	Names of others involved		

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. I ALSO UNDERSTAND I MAY BE REQUIRED TO UNDERGO DRUG/ALCOHOL TESTING PER NAC 284.888.

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 C-1 (Rev. 10/05)

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS

(Pursuant to NRS 616C.050)