

**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 <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)
Mailing Address				Age	Height	Weight	Social Security Number
City		State		Zip		Telephone	
Email Address						Primary Language Spoken	
<b>INSURER</b>			<b>THIRD-PARTY ADMINISTRATOR</b>			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			
<p style="color:red; font-size:small;">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 VETERANS 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 AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.</p>							
Date	Place		Employee's Original or Electronic Signature				
<b>THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT</b>							
Place		Name of Facility					
Date	Diagnosis and Description of Injury or Occupational Disease				<p style="color:red; font-size:small;">Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)</p>		
Hour							
Treatment:				<p style="color:red; font-size:small;">Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____</p>			
X-Ray Findings:				<p style="color:red; font-size:small;">From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> 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						<b>INSURER'S USE ONLY</b>	
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)			