NEVADA WORK INJURY REPORTING PROCEDURES

This Claim Packet is provided for your use in reporting employee work related injuries. Copy the enclosed forms as needed.

Notice of Injury or Occupational Disease (C-1) and Employer's Report of Industrial Injury or Occupational Disease (C-3)

The Notice of Injury or Occupational Disease (C-1) must be completed by the claimant within seven (7) days after an injury or occupational disease arises out of and in the course of employment. If medical treatment is sought, an Employee's Claim Compensation/Report of Initial Treatment (C-4) must be completed by the treating physician within three (3) working days of the treatment and mailed to the employer. The original form(s) should be immediately mailed, faxed or e-mailed to us. You must complete and mail The Employer's Report of Industrial Injury or Occupational Disease (C-3) to us within six (6) working days of receipt of the C-4. As an alternative, Notices of Injury or Occupational Disease (C-1) may be submitted online at www.berkindcomp.com. Maintain a copy for your records. Keep a separate file for each workers' compensation claim (do not maintain with other personnel records).

Supervisor's Report

The supervisor should fill out this form as soon as the accident is reported. The original should be submitted with the Notice of Injury or Occupational Disease (C-1). If the Notice of Injury or Occupational Disease (C-1) is reported online, then please mail, fax or e-mail the Supervisor's Report to us. Maintain a copy for your records. If you utilize another version of a supervisor's report, it may be substituted for the enclosed report.

Employer's Wage Verification Form (D-8)

The Employer's Wage Verification Form must be completed on claims involving lost time from work.

Please contact our claims department if you have questions about completing the Average Weekly Wage Worksheet.

Do not delay reporting the Notice of Injury or Occupational Disease (C-1) for completion of the Employer's Wage Verification Form.

Work Status

You must immediately notify Berkley Industrial Comp if an employee begins to lose time from work. You must immediately notify us of the date the employee is scheduled to return to any type work (full duty, modified duty, light duty).

"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? ____ **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? (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.

______________________________________ ______________________________________

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

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

For assistance with Workers' Compensation Issues: you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Reset Form

Print Form

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name | Nature of Business (mfg, etc.) | FEIN | OSHA Log Number

Office Mail | Location . . if different from mailing address | Telephone Number

City, State, Zip Code | INSURER | THIRD PARTY ADMINISTRATOR

EMPLOYEE

First Name | M.I. | Last Name | Social Security | Birthdate | Age | Primary Language Spoken

Home Address (Number and Street)

Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

City | State | Zip

Was the employee paid for the day of injury? ☐ Yes ☐ No

How long has this person been employed by you in Nevada?

In which state was employee hired? | Employee's occupation (job title) when hired or disabled | Department in which regularly employed:

Telephone

Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? ☐ Corporate Officer ☐ Sole Proprietor ☐ Partner

Was employee in your employ when injured or disabled by occupational disease (O/D)? ☐ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable) | Time of injury (Hours; Minute AM/PM) (if applicable) | Date employer notified of injury or O/D | Supervisor to whom injury or O/D reported

Address or location of accident (Also provide city, county, state) (if applicable)

Accident on employer's premises? (if applicable) ☐ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)

Witness

Was more than one person injured in this accident? (if applicable) ☐ Yes ☐ No

Part of body injured or affected | If fatal, give date of death | Witness

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.) | Witness

Did employee return to work next scheduled shift after accident? (if applicable) ☐ Yes ☐ No

Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason .

Location of Initial Treatment

Treating physician/chiropractor name

Emergency Room? ☐ Yes ☐ No Hospitalized? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

IMPORTANT How many days per week does employee work? From ☐ AM ☐ PM to ☐ AM ☐ PM

Last day wages were earned

Scheduled Days Off ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating

Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

Date employee was hired | Last day of work after injury or disability | Date of return to work | Number of work days lost

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No

If no, for how many hours a week was the employee hired?

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No

For the purpose of calculation of the average monthly wage, indicate the employee's gross earning by pay period for 12 weeks prior to the date of injury or disability. **If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8)**. Gross earnings will include overtime, bonuses, and other renumeration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hireto the date of injury or disability.

Pay Period ends on: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Employee is paid: ☐ Weekly ☐ Monthly ☐ Other ☐ BiWeekly ☐ Bi-Monthly

On the date of injury or disability the employee's wage was: ______ per ☐ Hour ☐ Week ☐ Day ☐ Month

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

I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title | Date

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ Third-Party

Deemed Wage | Account No. | Class Code

Claims Examiner's Signature | Date | Status Clerk | Date

EMPLOYER'S WAGE VERIFICATION FORM
(Pursuant to NRS 616C.045(2)(d))

Please provide the following information for the employee named below by completing this form. The information is needed so that the amount of disability compensation to which your employee is entitled may be calculated. Prompt completion and return of this form will ensure the timely payment of any compensation due this injured worker. Please answer all questions and sign the form where indicated.

EMPLOYER: PLEASE PROVIDE THE FOLLOWING INFORMATION ANSWERING ALL QUESTIONS

Date: ___________________ Injured Employee's Name (Last/First/M.I.): __________________________ Social Security # _________________________

Claim No.: ____________________________________ Date of Injury: ______________________________ Date of Hire: ___________________________

Was employee hired to work 40 hours per week: [ ] Yes [ ] No If no, # of hours per week: _________________ # of days per week: _________________

On the date of injury, the employee's wage was: $ _______ per [ ] Hour [ ] Day [ ] Week [ ] Month Date the wage became effective: ___________________

Was vacation paid during the applicable twelve week period?______________ If so, during what pay period? _____________________________________

Was sick leave paid during the applicable twelve week period? _____________ Was the injured employee paid for any holidays during the applicable twelve week period? _________ Did employee receive payment for overtime during the applicable twelve week period? ____________ Did employee receive termination pay during the applicable twelve week period? ________

Provide prior wage if current wage was in effect less than 12 weeks prior to date of injury: $ ______ per [ ] Hour [ ] Day [ ] Week [ ] Month

During this 12-week period did employee change to a job with different (1) duties, (2) hours of employment, (3) rate of pay? [ ] Yes [ ] No

If so, date: _______________________ Explain: ____

Does the employee receive commissions? [ ] Yes [ ] No Period of commission earned __________ to __________.

Indicate the amount of commission received over the last 6 months, or since date of hire: $ ________________

Does the employee receive bonuses/incentive pay? [ ] Yes [ ] No Period of bonuses/incentive pay earned _________ to _________.

Indicate the amount of bonuses received over last 12 months, or since date of hire: $ _____________________

Are the commission and bonus amounts included in GROSS EARNINGS below? [ ] Yes [ ] No

Does the employee declare tips for the purpose of worker's compensation? [ ] Yes [ ] No **See payroll declaration below. Attach declaration forms.**

Does the employee receive meals or lodging (excluding reimbursement for travel per diem)? [ ] Yes [ ] No **(Do not include in gross earnings)**

How many meals per day?______________ Monetary value of meals $____________________per [ ] Day [ ] Week [ ] Month

Lodging $_____________________per [ ] Day [ ] Week [ ] Month

TWELVE WEEK VERIFICATION FROM PAYROLL RECORDS. Report GROSS EARNINGS, include overtime payment and any other remuneration (except reimbursement for expenses). (See NAC 616C.423)

Give payroll information from _______ through ______. If employed less than twelve weeks, give gross earnings from date of hire to date of injury.

If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.

1. Certified illness or disability; 2. Institutionalized in a hospital, or other institution; 3. Enrolled as full-time student, not employed on days of attendance; 4. In military service other than training duty conducted on weekends; 5. Absent because of officially sanctioned strike; 6. Absence because of leave approved pursuant to Family and Medical Leave Act.

Payroll Period Beginning Ending	Gross Salary (Excluding Tips)	Declared Tips	Payroll Period Beginning Ending	Gross Salary (Excluding Tips)	Declared Tips

Dates of Absence Begin	End	Reason	Dates of Absence Begin	End	Reason	Dates of Absence Begin	End	Reason

Pay period ends on (check one) [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday
Employee is paid: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other
Employee scheduled day(s) off: [ ] Sunday [ ] Monday [ ] Tuesday [ ] Wednesday [ ] Thursday [ ] Friday [ ] Saturday [ ] Other
Explain "other":
Date the employee last worked AFTER injury occurred: _______________ Date returned to work: _________________

This information is true and correct as taken from the employee's payroll records.

Print Name: ____________________________________ Signature: ____

Date: ____ Employer: ____

Insurer: _______________________________________ Third-Party Administrator: ____________________________________

State of Nevada
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

A T T E N T I O N

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

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Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

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Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer,** by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

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For Assistance with Workers' Compensation Issues: You may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: http:/govcha.state.nv.us, E-mail cha@govcha.state.nv.us

The information in this publication is derived from Chapters 616A and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator:____________________ Contact Person: ____________________

Address:____________________ Telephone Number: ____________________
City State Zip

MCO/Health Care Provider:____________________ Contact Person: ____________________

Address:____________________ Telephone Number: ____________________
City State Zip