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

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Nye County	County	88-6000111	

Office Mail Address	Location . . . If different from mailing address	Telephone
2100 E Walt Williams #110		(800) 291-6826

City	State	Zip	INSURER	THIRD-PARTY ADMINISTRATOR
Pahrump	NV	89048	P A C T	Alternative Service Concepts

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? (If applicable) ☐ 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? ☐ Yes ☐ No . . . sole proprietor? ☐ Yes ☐ No . . . partner? ☐ Yes ☐ No	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 there 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 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	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

IMPORTANT LOST TIME INFO

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 not, 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 ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings 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 remuneration, 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 hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	Emloyee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	On the date of injury or disability the employee's wage was: $ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

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 ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date