

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

* Complete and attach Release of Information (Form C-4A) when injured employee signs C-4 Form electronically

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE

Form C-4 (rev.08/21)