Need to file a Workers' Compensation claim?

We make the process easy and stress free.

At Great American, we understand that filing a claim can be upsetting and stressful. That's why we give you multiple ways to report your claim.

Before reporting your claim, please have ready:

- Your policy number
- Complete and accurate information regarding the claim.

Call our reporting center

877-836-1555

Preregistration Required

To set up and gain access to our online system

Call **860-683-7078**

Once registered, report a claim online

www.Netclaim.net

So that you're best prepared to report the claim, please see the reverse side for information we may request from you.

We support employers' return to work plans, and make every effort to assist you with yours. Please report a claim as soon as you are aware of it. We are available 24 hours a day, seven days a week!

Thank you for choosing Great American Insurance Group!

GREAT AMERICAN INSURANCE GROUP

Accident Information:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

Employee Information:

- Name, physical home address, county, and home phone
- Date of birth, Social Security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

Medical Provider Information:

- Name of clinic/doctor's office where employee was treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

After you report a claim, the Claim Reporting Center:

- Assigns your claim to an Alternative Markets Claim professional who will contact you and your employee to acknowledge the claim and initiate the process.
- Provides you with a copy of the First Report of Injury.
- Sends this report directly to the state either by mail or electronic submission, based on your state's requirements.

Alternative Markets
Claim Reporting Center:

877-836-1555

Call Preparation Guide For
Workers' Compensation Claims

Gathering complete and accurate information is the first step toward a fair and timely resolution of any claim.

When you contact the Alternative Markets Claim Reporting Center to report a claim, you will be asked a series of questions needed to complete the First Report of Injury. The items listed on the reverse side will assist with your preparation.

Once the data is collected by the Claim Reporting Center:

- Your claim will be assigned to an Alternative Markets Claim professional who will contact you to acknowledge the claim and initiate the process.
- You and your employee will receive an acknowledgment letter with the claim number and information needed to contact us directly.
- The Claim Reporting Center provides you with a copy of the First Report of Injury.
- This report will be sent directly to the state either by mail or electronic submission, based on your state's requirements.

We support employers' return to work plans, and make every effort to assist you with yours. **Please report a claim as soon as you are aware of it to 877-836-1555.**
We are here 24/7!

GREAT AMERICAN INSURANCE GROUP
Alternative Markets

Alternative Markets Claim Reporting Center:

877-836-1555

Call Preparation Guide For Workers' Compensation Claims

POLICY NUMBER: _____

ACCIDENT INFORMATION:

- Loss date and time of injury
- Date injury/occurrence reported to employer
- Time the accident was reported
- Who was the claim reported to?
- Supervisor name
- City, state, county where accident occurred
- Employer/Insured name, phone number
- What was employee doing at the time of the accident?
- Last date employee worked
- First full work day lost as a result of this injury
- Did the employee receive wage continuation (pay while off work due to injury)?
- Has employee returned to work?
- Date returned
- Was there a witness to the accident?
- Name, address and phone number of witness(es)

EMPLOYEE INFORMATION:

- Name, physical home address, county, and home phone
- Date of birth, social security number, gender, marital status
- Regular occupation
- Department where employee regularly works
- State in which the employee was hired
- Name, address, phone number of contact person

MEDICAL PROVIDER INFORMATION:

- Name of clinic/doctor's office where employee treated
- Name of treating physician, address, phone
- Name, address and phone number of hospital where employee was treated following injury

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 #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**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? (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

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 #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**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? (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

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★ 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

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 #
Office Mail Address	Location . . . If different from mailing address		Telephone
City State Zip	**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? (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? . . . sole proprietor? . . . partner? ☐ Yes ☐ No ☐ Yes ☐ No ☐ 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.

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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

"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?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
____ YES ____ NO		____ YES ____ NO	

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
____ YES ____ NO		

Did the accident happen in the normal course of work? (if applicable)	
____ YES ____ NO	

Was anyone else involved?	Names of others involved
____ YES ____ NO	

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

C-1 (Rev. 10/05)

"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

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Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

"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

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Employee should sign, date and retain a copy.
Original to Employer, Copy to Employee

C-1 (Rev. 10/05)

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

Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence 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: _____

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

Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence 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: _____

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

Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence End	Reason	Dates of Absence Begin	Dates of Absence 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: _____

APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

Name (Last, First, Middle Initial)			Claim Number
Present Address (P.O. Box, Apt. No., Street)			Social Security Number
City	State	Zip	Date of Injury
Residence at time of injury:			(For Insurer's Use Only) [ ] Approved [ ] Disapproved Initials & Date

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

Date	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel Time	Daily Expense Reimbursement				Miles One Way	Mileage Allowed (For Insurers Use Only)
					Meals			Lodging		
					B	L	D			
								TOTAL MILES:		

Total of _____ Miles X 2 @ $ _____ . ____ per Mile =

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

_____ _____

Injured Employee's Signature Date

Reimbursement for Costs of Transportation and Meals

Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

NAC 616C.153 Reimbursement for air fare. With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

NAC 616C.156 Limitations on reimbursements.

1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

An injured employee or any other person who knowingly makes a false statement or representation or knowingly conceals a material fact in order to obtain or attempt to obtain any benefit may be subject to both civil penalties and criminal prosecution. If convicted, a person forfeits all rights to workers' compensation benefits and is liable for reasonable investigation costs of the insurer and attorney general's office, court costs, and restitution for payment or benefits fraudulently obtained. If the amount of the benefit or payment is less than $250, the penalty is a misdemeanor which may result in county jail time not to exceed six months and a fine up to $1,000. If the amount of the benefit or payment is $250 or more, the penalty is a category D felony which may result in imprisonment in the state prison for at least 1 year and not more than 4 years and a fine up to $5,000. Insurance fraud includes, but is not limited to: 1) requesting temporary total disability compensation or rehabilitation maintenance compensation while gainfully employed; 2) making false statements about potential employer contacts, mileage or compensation, 3) misrepresenting facts concerning an industrial accident, injury or illness to others such as an employer, insurer, physician or chiropractor, vocational rehabilitation counselor, and 4) filing an invalid claim in order to obtain controlled substances.

If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

APPLICATION FOR REIMBURSEMENT OF CLAIM RELATED TRAVEL EXPENSES

(Pursuant to NAC 616C.150)

Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

Name (Last, First, Middle Initial)			Claim Number
Present Address (P.O. Box, Apt. No., Street)			Social Security Number
City	State	Zip	Date of Injury
Residence at time of injury:			(For Insurer's Use Only) [ ] Approved _____ [ ] Disapproved Initials & Date

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

Date	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel Time	Daily Expense Reimbursement				Miles One Way	Mileage Allowed (For Insurers Use Only)
					Meals			Lodging		
					B	L	D			
								TOTAL MILES:		

Total of _____ Miles X 2 @ $ _____ . ____ per Mile =

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

_____ _____

Injured Employee's Signature Date

Reimbursement for Costs of Transportation and Meals

Nevada Administrative Code (NAC) 616C.150 Eligibility and computation.

1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives medical care; or

(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

2. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee, whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer or employer within 60 days after the expenses are incurred.

NAC 616C.153 Reimbursement for air fare. With the prior approval of the insurer or those employers who have elected to provide accident benefits, an injured employee may be reimbursed for air fare where the time, distance, convenience or cost justifies his travel by air.

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1. Unless otherwise directed or approved by the insurer, or the injured employee's treating physician or chiropractor, an injured employee who chooses to obtain his medical services at a more distant place although adequate medical care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

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Please type or print and provide all the information requested. Keep and be prepared to provide, if requested, any receipts relating to your reimbursement request.

Name (Last, First, Middle Initial)			Claim Number
Present Address (P.O. Box, Apt. No., Street)			Social Security Number
City	State	Zip	Date of Injury
Residence at time of injury:			(For Insurer's Use Only) [ ] Approved [ ] Disapproved Initials & Date

REPORT TRAVEL WEEKLY. See reverse side of this form for the regulations under which you may be reimbursed for claim related travel. **Be aware that any misrepresentation may be considered fraud and is in violation of Nevada law.**

Date	Beginning Point of Travel Address	Destination Name/Address	Enter Travel Time	Leave Travel Time	Daily Expense Reimbursement				Miles One Way	Mileage Allowed (For Insurers Use Only)
					Meals			Lodging		
					B	L	D			
								TOTAL MILES:		

Total of _____ Miles X 2 @ $ _____ . ____ per Mile =

I hereby certify that the record provided above is correct to the best of my knowledge and that all of the mileage for which I am requesting reimbursement is related to or is for treatment authorized under Nevada Revised Statute (NRS) 616A to 616D, inclusive or chapter 617 of NRS. **I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties.** I certify under penalty of perjury that the above information is correct to the best of my knowledge.

_____ _____

Injured Employee's Signature Date

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1. The insurer, or those employers who have elected to provide accident benefits, shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

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(b) His place of employment to the place where he receives medical care if the care is required during his normal working hours.

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3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any one week for medical care or for attendance at the system's rehabilitation center is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

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5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his home or place of employment until after 7:00 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

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2. If a person moves outside this state or to a new location within this state for his own convenience after becoming an injured employee, the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with an injured employee unless there is a medical necessity that precludes the injured employee from traveling alone. The medical necessity must be substantiated in writing by the injured employee's treating physician or chiropractor.

Notice

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If the employee is so severely injured that he is unable to complete this form, a friend, member of the family, labor representative, or other agent may complete and sign for the injured employee.

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: _____

EMPLOYEE: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

DEPARTMENT: _____

SOCIAL SECURITY NUMBER: _____

PAY PERIOD: _____ TO _____

AMOUNT OF TIPS RECEIVED DURING PERIOD: $_____

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

_____ _____

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: _____

EMPLOYEE: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

DEPARTMENT: _____

SOCIAL SECURITY NUMBER: _____

PAY PERIOD: _____ TO _____

AMOUNT OF TIPS RECEIVED DURING PERIOD: $_____

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

_____ _____

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

EMPLOYEE'S DECLARATION OF ELECTION TO REPORT TIPS

For the Purpose of Workers' Compensation

Pursuant to NRS 616B.227

EMPLOYER: _____

EMPLOYEE: _____

EMPLOYEE IDENTIFICATION NUMBER: _____

DEPARTMENT: _____

SOCIAL SECURITY NUMBER: _____

PAY PERIOD: _____ TO _____

AMOUNT OF TIPS RECEIVED DURING PERIOD: $_____

I understand that the reporting of false information may disqualify me from receiving workers' compensation benefits, and may subject me to criminal and civil penalties. I declare under penalty of perjury that the information provided concerning the amount of tips which I have received is true and correct to the best of my knowledge. Those tips are declared as wages for the calculation of workers' compensation.

_____ _____

Employee Signature Date

THIS FORM MUST BE SUBMITTED TO YOUR EMPLOYER BEFORE THE END OF THE PAY PERIOD THAT FOLLOWS THE PAY PERIOD INDICATED ABOVE.

NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.

2. Upon receipt of such notice the employer shall:
   (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
   (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
   (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.

3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

State of Nevada
Department of Business and Industry
Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Please check one only: ☐ INITIAL REPORT ☐ UPDATE REPORT

ALL REPORTS (Complete this section for INITIAL REPORTS *AND* UPDATES)

Date Report Submitted (to WCS): _____
Insurer Name: _____
Insurer Certificate Number: _____ Insurer FEIN: _____
Employer Name: _____
Claim Number: _____
Submitted by: _____
Individual Name and Title (please print)
Company: _____ Insurer ☐
Address: _____ TPA ☐
City, State, Zip: _____ Other ☐
_____
Telephone E-mail Address

INITIAL & UPDATE REPORTS (Report within 30 days of acceptance/denial or any changes to the claim)

Date Claim (C-4) Received: _____ Date of Injury: _____
Claim Disposition: ☐ Accepted ☐ Denied Date Accepted/Denied: _____
Reason for Acceptance/Denial: _____
Statute/Reg. Citation:
Estimated Medical Costs of Claim: $ _____
Description of Nature of Claim: _____

NATURE OF CLAIM CODE (Select from the IAIABC Codes below):

☐ 61 ASBESTOSIS, LUNG DISEASE FROM INHALED ASBESTOS
☐ 62 BLACK LUNG, CHRONIC LUNG DISEASE/COAL
☐ 63 BYSSINOSIS, PNEUMOCONIOSIS FROM COTTON, FLAX
☐ 64 SILICOSIS, PNEUMOCONIOSIS FROM INHALED SILICA
☐ 65 RESPIRATORY DISORDERS, GASSES, FUMES, CHEMICALS, ETC.
☐ 60 DUST DISEASE, ALL OTHER PNEUMOCONIOSIS
☐ 73 CONTAGIOUS DISEASE, UNSPECIFIED
☐ 74 CANCER
☐ 75 AIDS
☐ 79 HEPATITIS C
☐ 03 ANGINA PECTORIS, CHEST PAIN
☐ 41 MYOCARDIAL INFARCTION, HEART DISEASE/CONDITIONS
☐ 00 OTHER **BE SPECIFIC** _____

Symptoms/Exposure Only: (No Confirmed Diagnosis) ☐ YES ☐ NO

UPDATE REPORTS ONLY (Report within 30 days of appeal, closure, reopening, or confirmed diagnosis)

Appeal(s) of Acceptance/Denial:
Date Appeal Filed: _____
Appeal ☐ 1st ☐ 2nd ☐ 3rd ☐ Other _____ Hearing Date: _____
Decision: ☐ Affirmed ☐ Modified ☐ Reversed ☐ Remanded
Decision Date: _____
Diagnosis Confirmed: ☐ YES ☐ NO
Did Nature of Claim Change? ☐ YES - NEW CODE # ___ ☐ NO
Additional Information/Explanation (include clarification of activity reported):

Initial Claim Closure Date:
Date Claim Reopened (if applicable):
Subsequent Claim Closure Date (if applicable):

State of Nevada
Department of Business and Industry
Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Please check one only: ☐ **INITIAL REPORT** ☐ **UPDATE REPORT**

ALL REPORTS (Complete this section for INITIAL REPORTS *AND* UPDATES)

Date Report Submitted (to WCS): _____
Insurer Name: _____
Insurer Certificate Number: _____ Insurer FEIN: _____
Employer Name: _____
Claim Number: _____
Submitted by: _____
Individual Name and Title (please print)
Company: _____ Insurer ☐
Address: _____ TPA ☐
City, State, Zip: _____ Other ☐
_____
Telephone E-mail Address

INITIAL & UPDATE REPORTS (Report within 30 days of acceptance/denial or any changes to the claim)

Date Claim (C-4) Received: _____ Date of Injury: _____
Claim Disposition: ☐ Accepted ☐ Denied Date Accepted/Denied: _____
Reason for Acceptance/Denial: _____
Statute/Reg. Citation:
Estimated Medical Costs of Claim: $ _____
Description of Nature of Claim: _____

NATURE OF CLAIM CODE (Select from the IAIABC Codes below):

☐ 61 ASBESTOSIS, LUNG DISEASE FROM INHALED ASBESTOS
☐ 62 BLACK LUNG, CHRONIC LUNG DISEASE/COAL
☐ 63 BYSSINOSIS, PNEUMOCONIOSIS FROM COTTON, FLAX
☐ 64 SILICOSIS, PNEUMOCONIOSIS FROM INHALED SILICA
☐ 65 RESPIRATORY DISORDERS, GASSES, FUMES, CHEMICALS, ETC.
☐ 60 DUST DISEASE, ALL OTHER PNEUMOCONIOSIS
☐ 73 CONTAGIOUS DISEASE, UNSPECIFIED
☐ 74 CANCER
☐ 75 AIDS
☐ 79 HEPATITIS C
☐ 03 ANGINA PECTORIS, CHEST PAIN
☐ 41 MYOCARDIAL INFARCTION, HEART DISEASE/CONDITIONS
☐ 00 OTHER **BE SPECIFIC** _____

Symptoms/Exposure Only: (No Confirmed Diagnosis) ☐ YES ☐ NO

UPDATE REPORTS ONLY (Report within 30 days of appeal, closure, reopening, or confirmed diagnosis)

Appeal(s) of Acceptance/Denial:
Date Appeal Filed: _____
Appeal ☐ 1st ☐ 2nd ☐ 3rd ☐ Other _____ Hearing Date: _____
Decision: ☐ Affirmed ☐ Modified ☐ Reversed ☐ Remanded
Decision Date: _____
Diagnosis Confirmed: ☐ **YES** ☐ **NO**
Did Nature of Claim Change? ☐ YES - NEW CODE # ___ ☐ NO
Additional Information/Explanation (include clarification of activity reported):

Initial Claim Closure Date:
Date Claim Reopened (if applicable):
Subsequent Claim Closure Date (if applicable):

State of Nevada
Department of Business and Industry
Division of Industrial Relations

OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Please check one only: ☐ INITIAL REPORT ☐ UPDATE REPORT

ALL REPORTS (Complete this section for INITIAL REPORTS *AND* UPDATES)

Date Report Submitted (to WCS): _____
Insurer Name: _____
Insurer Certificate Number: _____ Insurer FEIN: _____
Employer Name: _____
Claim Number: _____
Submitted by: _____
Individual Name and Title (please print)
Company: _____ Insurer ☐
Address: _____ TPA ☐
City, State, Zip: _____ Other ☐
_____
Telephone E-mail Address

INITIAL & UPDATE REPORTS (Report within 30 days of acceptance/denial or any changes to the claim)

Date Claim (C-4) Received: _____ Date of Injury: _____
Claim Disposition: ☐ Accepted ☐ Denied Date Accepted/Denied: _____
Reason for Acceptance/Denial: _____
Statute/Reg. Citation:
Estimated Medical Costs of Claim: $ _____
Description of Nature of Claim: _____

NATURE OF CLAIM CODE (Select from the IAIABC Codes below):

☐ 61 ASBESTOSIS, LUNG DISEASE FROM INHALED ASBESTOS
☐ 62 BLACK LUNG, CHRONIC LUNG DISEASE/COAL
☐ 63 BYSSINOSIS, PNEUMOCONIOSIS FROM COTTON, FLAX
☐ 64 SILICOSIS, PNEUMOCONIOSIS FROM INHALED SILICA
☐ 65 RESPIRATORY DISORDERS, GASSES, FUMES, CHEMICALS, ETC.
☐ 60 DUST DISEASE, ALL OTHER PNEUMOCONIOSIS
☐ 73 CONTAGIOUS DISEASE, UNSPECIFIED
☐ 74 CANCER
☐ 75 AIDS
☐ 79 HEPATITIS C
☐ 03 ANGINA PECTORIS, CHEST PAIN
☐ 41 MYOCARDIAL INFARCTION, HEART DISEASE/CONDITIONS
☐ 00 OTHER **BE SPECIFIC** _____

Symptoms/Exposure Only: (No Confirmed Diagnosis) ☐ YES ☐ NO

UPDATE REPORTS ONLY (Report within 30 days of appeal, closure, reopening, or confirmed diagnosis)

Appeal(s) of Acceptance/Denial:
Date Appeal Filed: _____
Appeal ☐ 1st ☐ 2nd ☐ 3rd ☐ Other _____ Hearing Date: _____
Decision: ☐ Affirmed ☐ Modified ☐ Reversed ☐ Remanded
Decision Date: _____
Diagnosis Confirmed: ☐ YES ☐ NO
Did Nature of Claim Change? ☐ YES - NEW CODE # ___ ☐ NO
Additional Information/Explanation (include clarification of activity reported):

Initial Claim Closure Date:
Date Claim Reopened (if applicable):
Subsequent Claim Closure Date (if applicable):

NOTIFICACIÓN A LOS EMPLEADOS

A tenor de lo estipulado en: **NRS 616B.227 Opción de los empleados para reportar sus propinas; efecto; regulación.**

1. Para los propósitos del seguro contra accidentes laborales (*workers' compensation*), el empleado podrá optar por reportar la cantidad de propinas recibidas para los propósitos de calcular la compensación, remitiéndole a la empresa contratante (su empleador) el formulario *Employee's Declaration of Election to Report Tips* (formulario D-23). El empleado tendrá que elegir su opción separadamente, por cada período de pago, antes de cumplirse el siguiente día de pago. La declaración no podrá ser enmendada.

2. Al recibir dicha notificación, la empresa contratante tendrá que:

   (a) Sacarle una copia a cada reporte remitido por el empleado a la empresa contratante, con la finalidad de reportar la cantidad de sus propinas al Servicio de Rentas Internas de los Estados Unidos de América (*United States Internal Revenue Service*) o remitir el formulario *Employee's Declaration of Election to Report Tips*;

   (b) Remitir una copia a la compañía de seguros contra accidentes laborales, cuando la misma la solicitara, o si la empresa contratada fuere una entidad auto asegurada o una asociación pública o privada de empresas auto aseguradas, archivar una copia; y

   (c) Si no fuere una entidad auto asegurada, remitirle el pago de las primas a la compañía aseguradora por concepto de las propinas reportadas, a tenor de la misma tarifa aplicable a los sueldos regulares.

3. El empleado que opte por reportar sus propinas no calificará para recibir una compensación adicional, a razón de dichas propinas, hasta que se cumpla un período de tres meses, contado a partir de la fecha en que la empresa contratante haya recibido el formulario *Employee's Declaration of Election to Report Tips*. Para los propósitos del seguro contra accidentes laborales, las propinas podrán ser reportadas, a tenor de lo estipulado bajo el reglamento 26 U.S.C. §6053(a) del Código de Rentas Internas o en el formulario D-23. El formulario D-3, utilizado para reportar las propinas, está disponible en la oficina de personal.

Si los formularios no estuvieren disponibles, comuníquese con un representante de la empresa contratante o con el Servicio de Rentas Internas.

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

ATTENTION

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

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 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. NAIW is an independent state agency and is not affiliated with any insurer. 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 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

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

D-1 (rev. 10/07)

Estado de Nevada

MINISTERIO DE ASUNTOS COMERCIALES E INDUSTRIALES

(DEPARTMENT OF BUSINESS & INDUSTRY)

DIVISIÓN DE RELACIONES INDUSTRIALES

(DIVISION OF INDUSTRIAL RELATIONS)

Sección de Indemnización por Accidentes Laborales (Worker's Compensation Section)

ATENCIÓN

Breve Descripción de Sus Derechos y Beneficios si se Lesionara en el Trabajo o sufriera una Enfermedad de Carácter Laboral

NOTICE

This is a translation of a document originally drawn up in English. Accordingly, it is understood that all legal rights, responsibilities and/or obligations are governed by the original English version of this document. Furthermore, we reserve the right to correct any errors in this document.

ADVERTENCIA

Ésta es la traducción de un documento originalmente redactado en inglés. Consiguientemente, hágase saber que todos los derechos legales, responsabilidades y/u obligaciones expresadas en el mismo se regirán por la versión original del documento expedida en inglés. Además, nosotros nos reservamos el derecho de corregir cualquier error en este documento.

Notificación de Lesión o Enfermedad de Carácter Laboral (Reporte de Incidente, Formulario C-1): Si usted sufriera una lesión o enfermedad de carácter laboral (*occupational disease*, OD por sus siglas en inglés) ocasionada por su trabajo y mientras se encontrara desempeñándolo, usted tendrá que proporcionar notificación escrita al respecto a su empleador lo antes posible, pero a más tardar 7 días después de la fecha del accidente o de la enfermedad de carácter laboral (OD). Su empleador mantendrá una cantidad suficiente de formularios (*Notice of Injury or Occupational Disease*).

Reclamación para Compensación (Formulario C-4): Si usted requiriera tratamiento médico, se le solicitará llenar el formulario C-4 (form C-4), el cual estará disponible en la instalación que dispense el tratamiento inicial. Dicho formulario, debidamente llenado, tendrá que ser remitido dentro de 90 días después del accidente o de la enfermedad de carácter laboral. El médico o quiropráctico interviniente, tendrá que llenar dicho formulario y remitirlo dentro de 3 días laborables contados a partir de la fecha del tratamiento a: el empleador, la compañía de seguros del empleador y al administrador intermediario.

Tratamiento Médico: Si usted requiriera tratamiento médico por concepto de su lesión o enfermedad de carácter laboral, se le podría requerir que elija uno de los médicos o quiroprácticos que aparece en la lista de profesionales proporcionada por la compañía de seguros contra accidentes laborales, si dicha compañía hubiese celebrado un contrato con una Organización de Atención Médica Coordinada (*Managed Care Organization* o MCO, por sus siglas en inglés) o una Organización de Proveedores Preferentes (*Preferred Provider Organization* o PPO, por sus siglas en inglés) o un grupo de proveedores de atención médica. Si el empleador no hubiese celebrado un contrato con una MCO o PPO, usted podrá elegir uno de los médicos o quiroprácticos integrados al Panel de Médicos y Quiroprácticos. Cualquier **costo médico** relacionado con su lesión industrial u OD será pagado por su compañía de seguros.

Incapacidad Total Temporal (TTD): Si su médico certificara que usted no puede trabajar por un período de por lo menos 5 días consecutivos ó 5 días cumulativos durante un período de 20 días o si le impusiera restricciones con las cuales su empleador no pudiera cumplir, usted podría calificar para una compensación por concepto de una TTD.

Incapacidad Parcial Temporal (TPD): Si al regresar a trabajar su sueldo fuera menor que la compensación por concepto de una Incapacidad Total Temporal (TTD) para la cual hubiera calificado, se podría requerir que la compañía de seguros le pague una compensación por concepto de dicha TPD, con la finalidad de compensar la diferencia entre su sueldo y la compensación por concepto de la TTD. La compensación por concepto de una TPD podrá ser pagada únicamente por un período máximo de 24 meses.

Incapacidad Parcial Permanente (PPD): Si usted mostrara los síntomas de una PPD después de que la condición médica ocasionada por su lesión o enfermedad de carácter laboral se haya estabilizado, su compañía de seguros, dentro de 30 días, tendrá que hacer los arreglos para una evaluación por un médico o quiropráctico evaluador para determinar la gravedad de su PPD. La cantidad de la indemnización por concepto de su PPD, dependerá de la fecha de la lesión, los resultados de la evaluación de dicha incapacidad, así como su edad y su sueldo.

Incapacidad Total Permanente (PTD): Si un médico o quiropráctico interviniente certificara que médicamente usted se encuentra permanente y totalmente incapacitado y su compañía aseguradora lo considerara en estado de Incapacidad Total Permanente (PTD), usted calificará para recibir indemnizaciones mensuales, hasta un máximo del 66 2/3% de su sueldo mensual promedio. La cantidad del beneficio por concepto de la PTD está sujeta a una reducción si usted hubiera sido indemnizado por concepto de una Incapacidad Parcial Permanente (PPD) en el pasado.

Servicios de Rehabilitación Vocacional: Si usted no pudiese regresar a trabajar debido a un impedimento físico permanente o alguna restricción permanente atribuible a una lesión o enfermedad de carácter laboral, usted podría calificar para los servicios de rehabilitación vocacional.

Reembolso por Concepto de Transportación y Sustento Diario: Usted podrá calificar para gastos de viajes y sustento diario relacionado con tratamiento médico.

Reanudación: Usted podría calificar para la reanudación de su reclamación si su condición empeorara después de que la reclamación haya sido cerrada.

Procedimiento de Apelación: Si usted no estuviese de acuerdo con la determinación emitida por escrito por la compañía de seguros o si la compañía de seguros no respondiera a su petición, usted podrá apelar dichos actos ante un **Funcionario Judicial del Ministerio de Administración (*Department of Administration, Hearing Officer*)**, siguiendo las instrucciones detalladas en su notificación de la determinación. Su apelación de la determinación tendrá que ser interpuesta dentro de 70 días, contados a partir de la fecha de la notificación de la determinación a: 1050 E. William Street, Suite 400, Carson City, Nevada 89701, ó 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. Si no estuviese de acuerdo con la decisión del Funcionario Judicial, usted podrá apelar dicha decisión ante un **Funcionario de Apelación del Ministerio de Administración *(Department of Administration, Appeals Officer)***. Su apelación de la decisión tendrá que ser interpuesta dentro de 30 días, contados a partir de la fecha de la notificación de la decisión del Funcionario Judicial a: 1050 E. William Street, Suite 450, Carson City, Nevada 89701, ó 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. Si no estuviese de acuerdo con la decisión del Funcionario de Apelación, usted podrá presentar una **petición para revisión judicial ante la Corte del Distrito**. Su apelación tendrá que ser formulada dentro de 30 días, contados a partir de la fecha de la decisión emitida por el Funcionario de Apelación. Usted podrá ser representado por un abogado, contratado y remunerado por usted. Para determinar si usted califica para ser representado por uno de los abogados de la NAIW, comuníquese con dicha Agencia.

Agencia de Abogados de Nevada para Trabajadores Lesionados (NAIW, por sus siglas en inglés): Si usted no estuviera de acuerdo con la decisión de un funcionario judicial, usted podrá solicitar que un abogado de la NAIW lo represente en una audiencia ante un Funcionario de Apelación, sin cargo alguno para usted. La NAIW es una agencia estatal independiente y no está afiliada a ninguna compañía de seguros. Para información referente a la denegación de beneficios comuníquese con la NAIW a: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, ó 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

Para Presentar una Queja ante la División: Si desea presentar una queja ante el Administrador de la División de Relaciones Industriales (DIR, por sus siglas en inglés), comuníquese con la Sección de Indemnización por Accidentes Laborales: Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, teléfono (775) 684-7270, ó 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, teléfono (702) 486-9080.

Para Asistencia por asuntos relacionados con Compensación para Trabajadores *(Workers' Compensation)*: Usted podrá comunicarse con la *Office of the Governor Consumer Health Assistance*, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Línea Telefónica Gratuita 1-888-333-1597, sitio Web: http://govcha.state.nv.us, E-mail cha@govcha.state.nv.us

La información contenida en esta publicación se deriva de los Capítulos 616A y 617 de los Estatutos Actualizados del Estado de Nevada y es proporcionada únicamente para mantenerlo informado. Si tuviera alguna pregunta referente a su lesión o su reclamación por concepto del seguro contra accidentes laborales, por favor comuníquese con:

Compañía de Seguros/Administrador: _____ Persona Contacto: _____

Domicilio: _____ Número de Teléfono: _____
Ciudad Estado Código postal

MCO/Proveedor de Atención Médica: _____ Persona Contacto: _____

Domicilio: _____ Número de Teléfono: _____
Ciudad Estado Código postal