Print Form

Reset Form

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer Churchill County

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 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 of which the employee first became aware of the connection between the condition and employment)

Name 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? ☐ Yes ☐ No

Was anyone else involved? ☐ Yes ☐ No

Names of other involved:

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGES 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

For assistance with Workers' Compensation Issues, you may contact the Office of the Governor's 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 of this form.

Original to Employer, Copy to Employee

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