

# "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? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, when (date and time)?		Has the employee returned to work? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Was first aid provided? <input type="checkbox"/> YES <input type="checkbox"/> 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)		<input type="checkbox"/> YES <input type="checkbox"/> NO			
Was anyone else involved? <input type="checkbox"/> YES <input type="checkbox"/> NO		Names of others involved			

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Injured or Disabled Employee \_\_\_\_\_ Date \_\_\_\_\_

TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

**For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: <http://dhhs.nv.gov/Programs/CHA/> E-mail: [cha@govcha.nv.gov](mailto:cha@govcha.nv.gov)**

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

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

<b>EMPLOYER</b>	Employer's Name		Nature of Business (mfg., etc.)		FEIN		OSHA Log #													
	Office Mail Address			Location . . . If different from mailing address			Telephone													
	City		State		Zip		<b>INSURER</b>													
<b>EMPLOYEE</b>	First Name		M.I.		Last Name		Social Security		Birthdate		Age		Primary Language Spoken							
	Home Address (Number and Street)						Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed											
	City		State		Zip		Was the employee paid for the day of injury? (If applicable) <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No						Was employee in your employ when injured or disabled by occupational disease (O/D)? <input type="checkbox"/> Yes <input type="checkbox"/> No											
	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											
<b>ACCIDENT OR DISEASE</b>	Address or location of accident (Also provide city, county, state) (if applicable)							Accident on employer's premises? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> 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.																			
<b>INJURY OR DISEASE</b>	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)  <input type="checkbox"/> Yes <input type="checkbox"/> 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													
	If validity of claim is doubted, state reason						Did employee return to next scheduled shift after accident? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No			Will you have light duty work available if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No										
	Treating physician/chiropractor name						Location of Initial Treatment			Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No										
	<b>IMPORTANT</b>		How many days per week does employee work?			From		<input type="checkbox"/> am <input type="checkbox"/> pm		To		<input type="checkbox"/> am <input type="checkbox"/> pm		Last day wages were earned						
	Scheduled days off		S <input type="checkbox"/>		M <input type="checkbox"/>		T <input type="checkbox"/>		W <input type="checkbox"/>		T <input type="checkbox"/>		F <input type="checkbox"/>		S <input type="checkbox"/>		Rotating <input type="checkbox"/>		Are you paying injured or disabled employee's wages during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>IMPORTANT LOST TIME INFO</b>	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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <b>If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8).</b> 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: <input type="checkbox"/> SUN <input type="checkbox"/> TUE <input type="checkbox"/> THUR <input type="checkbox"/> SAT <input type="checkbox"/> MON <input type="checkbox"/> WED <input type="checkbox"/> FRI			Employee is paid: <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER <input type="checkbox"/> BI-WKLY <input type="checkbox"/> SEMI-MONTHLY			On the date of injury or disability the employee's wage was: \$ _____ per <input type="checkbox"/> Hr <input type="checkbox"/> Day <input type="checkbox"/> Wk <input type="checkbox"/> Mo													
<b>For assistance with Workers' Compensation Issues you may contact the State of Nevada Office for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: <a href="http://dhhs.nv.gov/Programs/CHA/">http://dhhs.nv.gov/Programs/CHA/</a> E-mail: <a href="mailto:cha@govcha.nv.gov">cha@govcha.nv.gov</a></b>																				
<b>Insurer Use Only</b>	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										
	Claim is: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> 3 <sup>rd</sup> Party			Deemed Wage			Account No.			Class Code										
Claims Examiner's Signature						Date			Status Clerk			Date								

**EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT**

**FORM C-4**

PLEASE TYPE OR PRINT

**EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED**

<b>EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED</b>						
First Name		M.I.	Last Name		Birthdate	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Address			Age	Height	Weight	Social Security Number
City		State		Zip	Telephone	
Mailing Address		City		State	Zip	Primary Language Spoken
<b>INSURER</b>			<b>THIRD-PARTY ADMINISTRATOR</b>		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		
<p style="font-size: small; color: red;">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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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.</p>						
Date	Place		Employee's Signature			
<b>THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT</b>						
Place			Name of Facility			
Date	Diagnosis and Description of Injury or Occupational Disease			<p style="color: red;">Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident?  <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)</p>		
Hour						
Treatment:			<p style="color: red;">Have you advised the patient to remain off work five days or more?  <input type="checkbox"/> Yes Indicate dates: from _____ to _____  <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty                      If modified duty, specify any limitations/restrictions: _____</p>			
X-Ray Findings:			<p style="color: red;">From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="color: red;">Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p style="color: red;">Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)</p>						
Date	Print Doctor's Name		<p style="color: red;">I certify that the employer's copy of this form was mailed to the employer on:</p>			
Address					<b>INSURER'S USE ONLY</b>	
City	State	Zip	Provider's Tax I.D. Number	Telephone		
Doctor's Signature				Degree		



**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.

<b>If absent from work for the following reasons, please specify the date(s) absent and the number code for the reason of absence.</b>							
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	Gross Salary	Declared	Payroll Period	Gross Salary	Declared		
Beginning	Ending	Tips	Beginning	Ending	Tips		

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

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) <input type="checkbox"/> Approved _____ <input type="checkbox"/> 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			
<b>TOTAL MILES:</b>										
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.

State of Nevada  
Department of Business & Industry  
**Division of Industrial Relations**  
*Workers ' Compensation Section*

**ALTERNATIVE CHOICE OF PHYSICIAN or CHIROPRACTOR**  
**(NRS 616C.090)**

A list of the Panel of Treating Physicians or Chiropractors, or those health care providers, with whom your insurer has contracted, can be obtained from your insurer or third-party administrator upon written request. Your insurer or third-party administrator has within **3** working days to provide you the list pursuant to [NAC 616C.030](#).

If within the first 90 days after the date of injury, you are not satisfied with the first treating physician or chiropractor and

Your insurer has entered into a contract with a managed care organization or with health care providers; you must select an alternative physician or chiropractor according to the terms of the contract. This selection may be made without the prior approval of the insurer. If after choosing your physician or chiropractor, you move to a county not serviced by the contracted managed care organization or health care providers and the insurer deems it impractical for you to continue treating with the physician or chiropractor, you must choose a treating physician or chiropractor who has agreed to the terms of the contract unless the insurer authorizes you to choose another physician or chiropractor;

or

Your insurer has not entered into a contract with an organization for managed care, or with health care providers, you may select an alternative physician or chiropractor from the Panel of Treating Physicians and Chiropractors.

**NOTICE:** Any further changes in your treating physician or chiropractor must be in writing and approved by the insurer. If, at any time, you are dissatisfied with a physician or chiropractor selected by yourself, the insurer, managed care organization, or health care provider, a change may be made by submitting a written request to the insurer indicating the name of the alternate physician or chiropractor. The insurer shall approve or deny this request within ten (10) days after receipt of the written request or it shall be deemed approved. You will receive written notification if the insurer denies this request which will include the reason for the denial and appeal rights.



**REQUEST FOR REIMBURSEMENT OF EXPENSES FOR TRAVEL AND LOST WAGES**  
Pursuant to NRS 616C.365 and 616C.477

Claim No: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Insurer's Name: \_\_\_\_\_

Injured Employee's Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Present Employer: \_\_\_\_\_ Phone No: \_\_\_\_\_

Date of Hearing/Treatment: \_\_\_\_\_

Time of Hearing/Treatment: Begin \_\_\_\_\_ End \_\_\_\_\_

From: Place of Employment  Residence\*  (Check One) \*DO NOT USE RESIDENCE FOR EXTENDED TRAVEL BENEFIT

Address: \_\_\_\_\_

To: Place of Hearing/Treatment: \_\_\_\_\_

Address: \_\_\_\_\_

<b>FOR TRAVEL AND LOST WAGES FOR HEARINGS</b> Pursuant to NRS 616C.365	
Total Miles Traveled (One Way) . . . . .	<b>FOR INSURER'S USE</b>
Food . . . . .	Miles X 2 X
Lodging . . . . .	per mile =
Lost Wages . . . . .	
Total Expenses . . . . .	Total \$

<b>LOST WAGES COMPENSATION FOR EXTENDED MEDICAL TRAVEL</b>	
Pursuant to NRS 616C.477	
Employer at time of injury: _____	<b>FOR INSURER'S USE</b>
Total Miles Traveled (One Way) . . . . .	Qualify? <input type="checkbox"/> YES or <input type="checkbox"/> NO
Total Time Absent from Employment . . . . .	TTD <input type="checkbox"/> 50% or <input type="checkbox"/> 100 %
	TTD RATE \$

I declare under penalty of perjury that the above amounts were necessarily incurred and that they are true and correct to the best of my knowledge.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of 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.**