

| 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>THIRD-PARTY ADMINISTRATOR</b>   |  |
| <b>EMPLOYEE</b>  | First Name   |   | M.I.   | Last Name   |  | Social Security   | Birthdate  |  |
|  | 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 |  |   | Was employee in your employ when injured or disabled by occupational disease (O/D)? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |
| <b>ACCIDENT OR DISEASE</b>   | 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) <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)<br><br><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  | M   | T  | W   | T  | F   | S  |  |
| Rotating   | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/>  | <input type="checkbox"/>   | <input type="checkbox"/>  | <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. 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: <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 |
| <p><b>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: <a href="http://govcha.state.nv.us">http://govcha.state.nv.us</a> E-mail <a href="mailto:cha@govcha.state.nv.us">cha@govcha.state.nv.us</a></b></p> |  |   |  |   |  |   |  |  |
| ★  | 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   |  |
| <b>Insurer Use Only</b>  | 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   |  |