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 #
CITY OF WEST WENDOVER	MUNICIPALITY	88-0272071	

Office Mail Address	Location . . . If different from mailing address	Telephone
P.O. Box 2825	1111 Gene L. Jones Way	775-664-3081

City	State	Zip	INSURER	THIRD-PARTY ADMINISTRATOR
West Wendover	NV	89883	Davies Claims Solutions	PH: 1-800-291-6826

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.

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://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

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

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"
(Incident Report)
Pursuant to NRS 616C.015

Name of Employer CITY OF WEST WENDOVER P.O. Box 2825 West Wendover, NV 89883 PH: 775-664-3081

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

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://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

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

C-1 (Rev. 01/20)

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

To be completed by immediate supervisor within 24 hours of injury, regardless of the extent of injury, and returned to the Safety Secretary or City Office.

Agency / Department: _____

Name of Employee: _____ **Job Classification**: _____

Date of Injury: _____ **Time**: _____ **a.m. – p.m.** **Left Work**: _____ **a.m. – p.m.**

Names of Witnesses: _____

(Check Appropriate Information Below)

Body Part Injured			**Nature of Injury**			**Action**	
Face or Head	Trunk	Hands	Dermatitis	Foreign Body	Wounds	First Aid	Time Loss
Toes or Foot	Lungs	Knees	Amputation	Dislocation	Hernia	Death	Doctor's Care
Internal	Back	Arms	Contusion	Infection	Strain	Unknown	Hospitalized
Fingers	Legs	Eyes	Burns	Fracture	Sprain		
Other _____			Other _____				

DESCRIBE ACCIDENT – (What was person doing; what objects or substances were involved; etc.) _____

_____

_____

_____

Regular Days Off: _____ **Regular Shift**: _____ **a.m. – p.m.** _____ **a.m. - p.m.**

Light Duty Available: _____ Yes _____ No Describe: _____

SUPERVISOR'S INVESTIGATION OF CAUSE OF ACCIDENT / INJURY

Note: Employers Insurance Co. of Nevada C-3 Form must be completed if injury requires any medical treatment or time loss.

UNSAFE ACTS
( ) Operating Without Authority
( ) Operating at Unsafe Speed
( ) Making Safety Devices Inoperative
( ) Taking Unsafe Position
( ) Unsafe Lifting or Placing
( ) Working on Moving or Dangerous Equipment
( ) Failure to Use Personal Protective Equipment
( ) Safety Rule Violation
( ) Using Unsafe Equipment
( ) Other _____

UNSAFE CONDITIONS
( ) Improperly Guarded Equipment
( ) Defective Tools, Equipment, etc.
( ) Poor Housekeeping
( ) Improper Lighting
( ) Wet or Slippery Floor
( ) Unsafe Substance
( ) Combative Patient
( ) Unsafe Design or Construction
( ) Other _____

Reasons for unsafe act (Lack of training, disregard for authority, etc.) _____

_____

_____

What steps have been taken to prevent a recurrence? _____

_____

_____

( ) Check here if you believe injury was not work-related or valid occupational injury claim.

Have you reviewed this accident with the employee? _____ Yes _____ No

Employee Signature: _____ Date: _____

Immediate Supervisor's Signature: _____ Date: _____

Reviewed by Department Head: _____ Date: _____

REMARKS: _____

_____

_____

_____

DIAGRAM OF ACCIDENT AREA (If needed)

CITY OF WEST WENDOVER
1111 N Gene L Jones Way
P.O. Box 2825
West Wendover, NV 89883
PH: 775-664-3081
FX: 775-664-3720

NOTICE OF VEHICLE / PROPERTY DAMAGE
INCIDENT REPORT

***Note*:** This form is to be completed by the employee and filed by the employer.

DEPARTMENT:

Employee's Name:	Social Security Number:	Telephone Number:
Date of Accident:	Time of Accident:	Place Where Accident Occurred:
Briefly describe the accident or circumstances, along with description of vehicle/property damage:		
Vehicle Info: VIN #_____ MAKE_____ MODEL #_____ CITY UNIT #_____		
Name(s) of witness(es):		
Did you leave work because of the accident? ☐ Yes ☐ No	**If yes,** give date & time:	Have you returned to work? ☐ Yes ☐ No **If yes,** give date & time:
Was first aid provided? ☐ Yes ☐ No	**If yes,** by whom?	Did the accident happen in the normal course of your work? ☐ Yes ☐ No
Was anyone else involved? **If yes,** please provide the name(s) of those involved, in the space provided below: ☐ Yes ☐ No		Please provide the name and address of the treating physician, if applicable or known:

The employee must sign and date this form in the space provided below. The employer is also advised to retain a copy of the completed form.

Signature of Employee Involved:	Date:

With my signature below, I acknowledge receipt of this form on behalf of the employee named above.

Name of Dept. Head/Supervisor (Print):	Signature:	Date: