

ADMINISTRATOR: FIRSTIER ADMINISTRATORS, INC.

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 or Occupational Disease Nye County School District 775-727-7743 Fax: 775-727-7768								
EMPLOYER	Employer's Name NYE COUNTY SCHOOL DISTRICT		Nature of Business (mfg., etc.) EDUCATION		FEIN	OSHA Log #					
	Office Mail Address 484 S. WEST STREET		Location . . . If different from mailing address		Telephone 775-727-7743						
	City PAHRUMP	State NV	Zip 89048	INSURER NCSD		THIRD-PARTY ADMINISTRATOR					
EMPLOYEE	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? <input type="checkbox"/> Yes <input type="checkbox"/> No			. . . sole proprietor? <input type="checkbox"/> Yes <input type="checkbox"/> No		. . . 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	
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) <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.										
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)			
	Part of body injured or affected			If fatal, give date of death		Witness			<input type="checkbox"/> Yes <input type="checkbox"/> No		
	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						
	IMPORTANT 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		Are you paying injured or disabled employee's wages during disability? <input type="checkbox"/> Yes <input type="checkbox"/> No							
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: \$ _____ Hr <input type="checkbox"/> Day <input type="checkbox"/> Wk <input type="checkbox"/> No						
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: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> 3 rd Party				Deemed Wage		Account No.		Class Code		
	Claims Examiners' Signature				Date		Status Clerk		Date		

ORIGINAL - EMPLOYER
 Send Original to Ray Ritchie
 Southern District Office

Nye County School District
 484 S. West St.
 Pahrump, NV 89048