

**“NOTICE OF INJURY OR OCCUPATIONAL DISEASE”  
(Incident Report/Form C-1) – Pursuant to NRS 616C.015**



**Name of Employer: CLARK COUNTY SCHOOL DISTRICT**

Name of Employee		Social Security Number		Birth Date	Home Telephone Number
Home Address				Employee's Occupation (Job Title)	
Employee's scheduled days off	Sun <input type="checkbox"/>	Mon <input type="checkbox"/>	Tue <input type="checkbox"/>	Wed <input type="checkbox"/>	Thu <input type="checkbox"/>
	Fri <input type="checkbox"/>	Sat <input type="checkbox"/>	Employee's normal work hours	From _____	To _____
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:	
Did the injury involve a <i>sharp</i> such as a needlestick, disposable razor, or scalpel? _____ <b>YES</b> _____ <b>NO</b>				If yes, identify type/brand of <i>sharp</i> if known.	
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? _____ <b>YES</b> _____ <b>NO</b>	If yes, when (date and time)?		Has the employee returned to work? _____ <b>YES</b> _____ <b>NO</b>	If yes, when (date and time)?	
Was first aid provided? _____ <b>YES</b> _____ <b>NO</b>	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) _____ <b>YES</b> _____ <b>NO</b>					
Was anyone else involved? _____ <b>YES</b> _____ <b>NO</b>	Names of others involved:				

**Note to Employee:**  
**THE SCHOOL DISTRICT HAS MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURIES. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.**  
**TO FILE A CLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).**

**Note to Supervisor:**  
**PURSUANT TO NRS 616C.015 THE SIGNATURE OF THE SUPERVISOR IS AN ACKNOWLEDGMENT OF THE RECEIPT OF THIS NOTICE AND SHALL NOT BE DEEMED TO BE A WAIVER OF ANY OF THE SCHOOL DISTRICT'S DEFENSES OR RIGHTS.**

**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](mailto:cha@govcha.state.nv.us)**

**X** **SIGN HERE** **Must be signed and dated by Injured Employee**

Supervisor's Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature of Injured or Disabled Employee \_\_\_\_\_ Date \_\_\_\_\_

**BRIEF DESCRIPTION OF RIGHTS AND BENEFITS**  
**(Pursuant to NRS 616C.050)**

**Notice of Injury or Occupational Disease (Incident Report Form C-1):** If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

**Claim for Compensation (Form C-4):** If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

**Medical Treatment:** If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any medical costs related to your industrial injury or OD will be paid by your insurer.

**Temporary Total Disability (TTD):** If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

**Temporary Partial Disability (TPD):** If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

**Permanent Partial Disability (PPD):** When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation and your age and wage.

**Permanent Total Disability (PTD):** If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a PPD award.

**Vocational Rehabilitation Services:** You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

**Transportation and Per Diem Reimbursement:** You may be eligible for travel expenses and per diem associated with medical treatment.

**Reopening:** You may be able to reopen your claim if your condition worsens after claim closure.

**Appeal Process:** If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the Department of Administration, Hearing Officer, by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the Department of Administration, Appeals Officer. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a petition for judicial review with the District Court. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

**Nevada Attorney for Injured Workers (NAIW):** If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

**To File a Complaint with the Division:** If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89074, telephone (702) 486-9080.

**For assistance with Workers' Compensation Issues:** you may contact the Office of the Governor Consumer Health Assistance, 555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101, Toll Free 1-888-333-1597, Web site: <http://govcha.state.nv.us>, E-mail [cha@govcha.state.nv.us](mailto:cha@govcha.state.nv.us).