Workers' Compensation Reporting & Forms for *Retirees*

Claims

Retirees can file claims for:

- Heart/Lung
- Hearing
- Cancer
- Stress

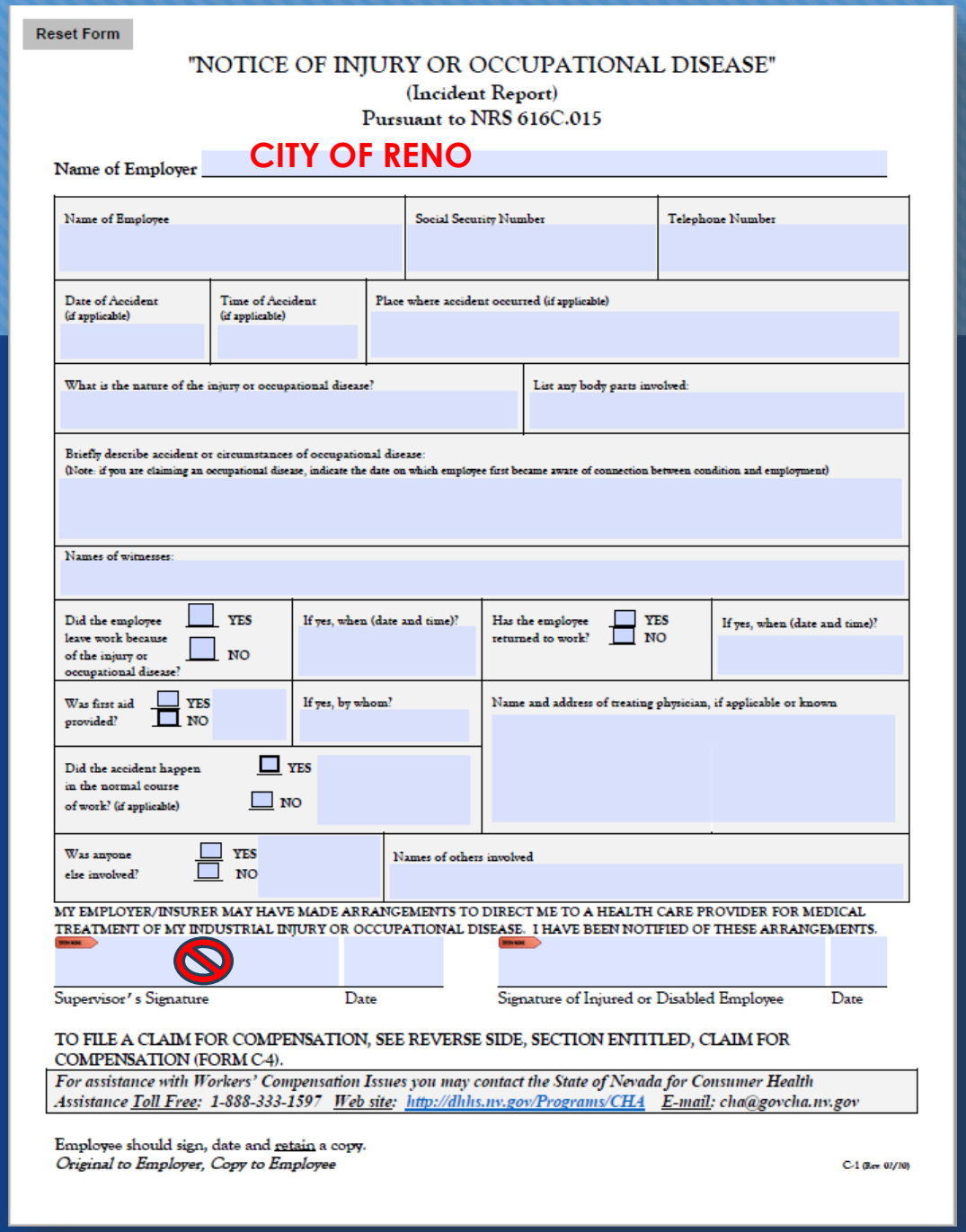
Contact City of Reno at **riskmgt@reno.gov** as soon as notified of a condition.

Reporting the injury C-1 Form

The C-1 form should be completed within 7 days of an incident or notification of a condition.

Fill in all applicable information. Write in "Retired or NA" in fields that don't apply. A supervisor signature is not needed.

If the injury is cumulative or not tied to a specific incident, your date of accident will be the date you were notified of the condition by a medical professional.



Reset Form

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

Name of Employer CITY OF RENO

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).

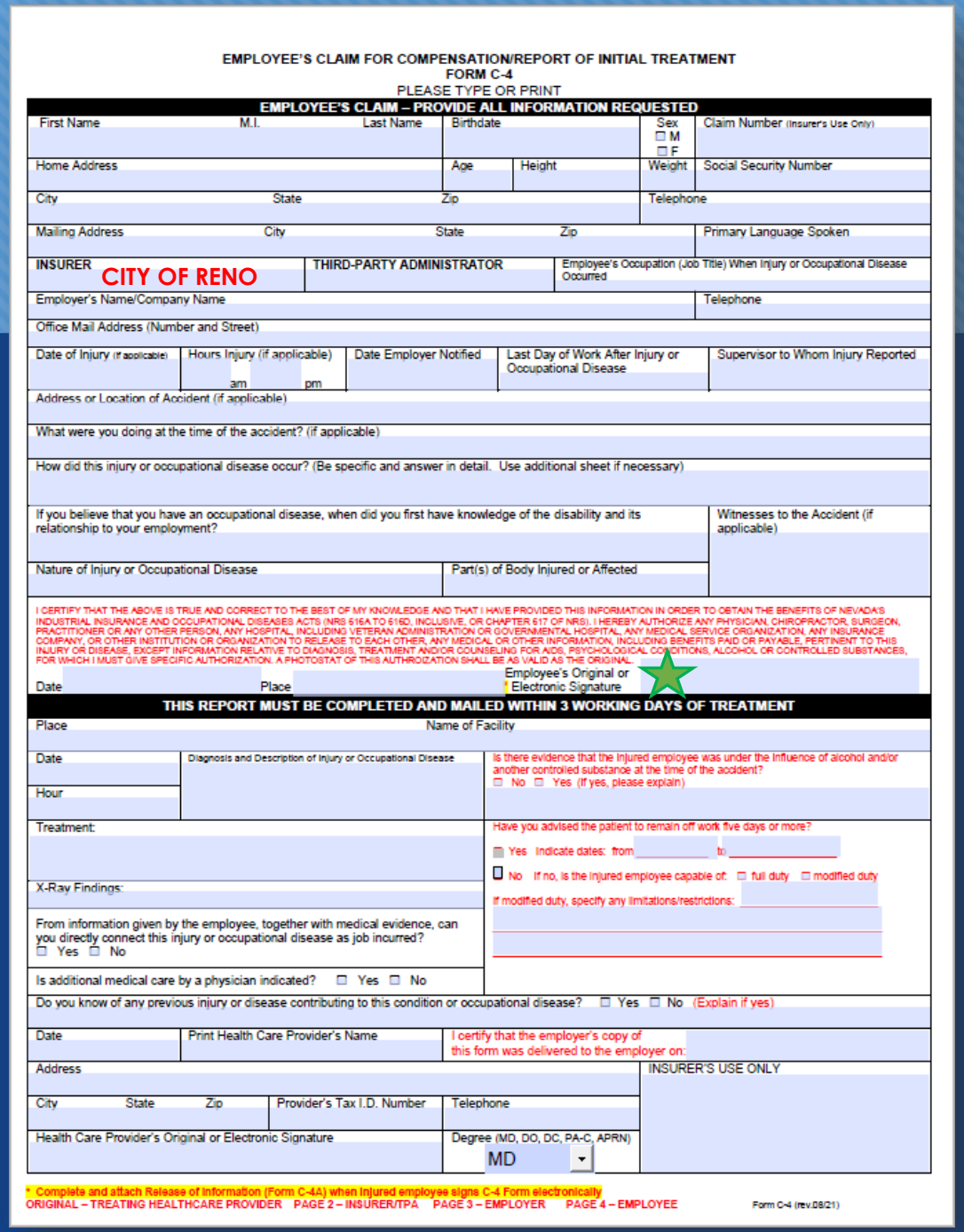
For assistance with Workers' Compensation Issues you may contact the State of Nevada for Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov

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

C-1 (Rev. 01/10)

Medical Care C-4 Form

- Your medical provider will need to complete a C-4 form. You will complete the top portion and your provider the second half. Please be sure to sign the form.
- This is the form that will initiate a workers' compensation claim, without it, a claim can't be started.
- If your provider will not fill a C-4, contact us.



EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT
FORM C-4
PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name | M.I. | Last Name | Birthdate | Sex ☐ M ☐ F | Claim Number (Insurer's Use Only)

Home Address | Age | Height | Weight | Social Security Number

City | State | Zip | Telephone

Mailing Address | City | State | Zip | Primary Language Spoken

INSURER CITY OF RENO | THIRD-PARTY ADMINISTRATOR | 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

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 ANY OTHER PERSON, ANY HOSPITAL, INCLUDING VETERAN 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.

Date | Place | Employee's Original or Electronic Signature

THIS REPORT MUST BE COMPLETED AND MAILED WITHIN 3 WORKING DAYS OF TREATMENT

Place | Name of Facility

Date | Hour | Diagnosis and Description of Injury or Occupational Disease | Is there evidence that the injured employee was under the influence of alcohol and/or another controlled substance at the time of the accident? ☐ No ☐ Yes (If yes, please explain)

Treatment: | Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from ____ to ____ ☐ No If no, is the injured employee capable of: ☐ full duty ☐ modified duty

X-Ray Findings: | If modified duty, specify any limitations/restrictions:

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? ☐ Yes ☐ No

Is additional medical care by a physician indicated? ☐ Yes ☐ No

Do you know of any previous injury or disease contributing to this condition or occupational disease? ☐ Yes ☐ No (Explain if yes)

Date | Print Health Care Provider's Name | I certify that the employer's copy of this form was delivered to the employer on:

Address | INSURER'S USE ONLY

City | State | Zip | Provider's Tax I.D. Number | Telephone

Health Care Provider's Original or Electronic Signature | Degree (MD, DO, DC, PA-C, APRN) MD

* Complete and attach Release of Information (Form C-4A) when injured employee signs C-4 Form electronically

ORIGINAL – TREATING HEALTHCARE PROVIDER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE

Form C-4 (rev.08/21)

Re-opening Process

You can request re-opening of a previously accepted claim if the work injury or condition changes or worsens.

You will need to:

1. Complete a written request for re-opening of the claim. If possible, include date of injury and claim number.
2. Request must include a medical report stating the following:
   - A change or worsening in your injury or condition
   - A need for treatment and a treatment plan
   - A direct relationship between your worsened condition and the original injury

Submit request and report via email to workcomp@reno.gov

Questions….

Contact us at

riskmgt@reno.gov

For forms visit

DIR Workers' Compensation Forms