## EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL TREATMENT FORM C-4

PLEASE TYPE OR PRINT

First Name	EMPLOYEE'S CLAIM - PROVIDE ALL INFORMATION REQUESTED									
City   State   Zip   Telephone	First Name							Sex		
Mailing Address  City  State  Zip  Primary Language Spoken  INSURER  THIRD-PARTY ADMINISTRATOR  Employer's Name-Company Name  In-House Production  Triephone (702) 631-4748  Office Mail Address (Number and Street)  6620 W Arby Ave.  Las Vegas. NV 89118  Date of Injury if expirates  Hours injury (if applicable)  The burs injury (if applicable)  What were you doing at the time of the 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)  What were you doing at the time of the accident? (if applicable)  How did this injury or occupational disease, when did you first have knowledge of the disability and its additional place and occupational disease. When did you first have knowledge of the disability and its additional place and occupational disease. When did you first have knowledge of the disability and its additional place and occupational disease. When did you first have knowledge of the disability and its additional place and occupational disease. When did you first have knowledge of the disability and its additional place and occupational disease. When did you first have knowledge of the disability and its additional place and occupational disease. When did you first have knowledge of the disability and its applicable)  Nature of Injury or Occupational Disease  Part(s) of Body Injured or Affected  Injury or Occupational Disease or the production of the pr	Home Address	_			Age	Height		Weight	Social Security Number	
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Telephone (702) 631-4748   Telephone (702) 631	Mailing Address	City			State Zip			Primary Language Spoken		
Office Mail Address (Number and Street) 6620 W Arby Ave. Las Vegas, NV 89118  Date of Injury or appriciable   Hours Injury (if applicable)   Date Employer Notified   Last Day of Work After Injury or Occupational Disease   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? (if applicable)    How did this injury or occupational disease occur? (if applicable)    If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?  If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?  If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?  If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?  If you believe that you have an occupational disease, when did you first have knowledge of the disability and its applicable)  Nature of injury or Occupational Disease  Part(s) of Body Injured or Affected  Part(s) of Body Injured or Affected  Part(s) of Body Injured or Affected  Part (s)	INSURER	THIRD-PARTY ADMINISTR				₹				
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### Witnesses to the 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?  Nature of Injury or Occupational Disease  Part(s) of Body Injured or Affected  I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE REST OF MY NEOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO GRIAN THE SHEFTS OF REVADA'S SURGEON, PRACTIFICABLE OF OFFICE AND CORRECT TO THE REST OF NEVADA'S SURGEON, PRACTIFICABLE OF OFFICE AND CORRECT TO THE REST OF NEVADA'S SURGEON, PRACTIFICABLE OF OFFICE AND CORRECT TO THE REST OF NEVADA'S SURGEON, PRACTIFICABLE OF OFFICE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO GRIAN THE SHEFTS OF REVADA'S SURGEON, PRACTIFICABLE OF OFFICE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO GRIAN THE SHEFTS OF REVADA'S SURGEON, PRACTIFICABLE OF OTHER PRESON, ANY HOSPITAL ANY MEDICAL OR OTHER INFORMATION, INC. LIDINGS SHEFTS TO ANY OFFICE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO GRIAN THE SHEFTS OF REVADA'S SURGEON, ANY HOSPITAL ANY MEDICAL OR OTHER INFORMATION, INC. LIDINGS SHEFTS TO AND OR RAYABLE. CONTROLLED WITHOUT ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY OFFI AND THE SHEFTS OF REVADA'S SURGEON. ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO AND OR RAYABLE. CONTROLLED WITHOUT ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY OFFI AND THE SHEFTS OF REVADA'S SURGEON. ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY MEDICAL OR OTHER INFORMATION INC. LIDINGS SHEFTS TO ANY MEDICAL SHEFTS OFFI ANY MEDICAL SHEFTS	Date of Injury (if applicable)	Hours Injury (if app	Notified Last Day of Work After Injury Supervisor to Whom Injury Reported							
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Industrial insurance and occurational diseases acts (INRS 616a To 616b, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHROPPACTOR, SURGEON, PRACTITIONER, OR OTHER INSTITUTION ANY HOSPITAL, INCLUDING PERHANS ADMINISTRATION OR OR CRANIZATION ANY HOSPITAL, ANY MEDICAL OR OTHER INSTITUTION OR OR CRANIZATION TO RELEASE TO EACH OTHER, ANY HEDICAL OR OTHER INFORMATION, NOCLUDING BENEFITS PAID OR PAYABLE. CONTROLLED SUBSTANCES, FOR WHICH INUST GIVE SPECIFIC AUTHORIZATION. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.    Date	Nature of Injury or Occupational Disease Part(s					s) of Body Injured or Affected				
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Place Name of Facility  Date Diagnosis and Description of Injury or Occupational Disease Hour  Treatment: Have you advised the patient to remain off work five days or more? Yes Indicate dates: from to	Date	Date Place					Employee's Signature			
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Address   Addr	Place Name of Facility									
Treatment:    Alave you advised the patient to remain off work five days or more?   Yes Indicate dates: from		Diagnosis and Description of Injury or Occupational Disease				and/or another controlled substance at the time of the accident?				
X-Ray Findings:    Yes   Indicate dates: from	Hour									
X-Ray Findings:  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 Doctor's Name  I certify that the employer's copy of this form was mailed to the employer on:  Address  INSURER'S USE ONLY	Treatment:						Have you advised the patient to remain off work five days or more?			
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?										
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Address  City State Zip Provider's Tax I.D. Number Telephone  this form was mailed to the employer on:  INSURER'S USE ONLY	Do you know of any previous injury or disease contributing to this condition or occupational disease?   Yes   No (Explain if yes)									
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