



FIRST AID BBP W/C

CITY OF HENDERSON

Human Resources

First Notice of Injury or Occupational Disease

SSN# <input type="text"/>	Employee # <input type="text"/>	Date of accident/injury <input type="text"/> / <input type="text"/> / <input type="text"/> Time <input type="text"/> a.m./p.m.
Name of employee <input type="text"/>		Did injury occur on employer premises? YES <input type="checkbox"/> NO <input type="checkbox"/>
Department <input type="text"/>	Job title <input type="text"/>	Accident/Injury location - address <input type="text"/>
Supervisor to whom reported <input type="text"/>		Date/Time reported: (Explain if not reported immediately) <input type="text"/>
Supervisor on duty at time of accident/injury <input type="text"/>		Witness(es) Name <input type="text"/>
Employee on overtime? YES <input type="checkbox"/> NO <input type="checkbox"/>	Scheduled days off: <input type="text"/> to <input type="text"/> Reg. Working Hours <input type="text"/>	
No. of days worked per week <input type="text"/>		(Not # of days)

Describe accident/injury in detail beginning with what you were doing when it occurred.*

Equipment, tools furniture, etc., connected with accident/injury

Unsafe conditions or practice involved

What can be done to prevent reoccurrence?

Did the accident happen in the normal course of work? YES NO

Was anyone else involved? YES NO Names

BODY PART INJURY (be specific)	NATURE OF INJURY	ACTION TAKEN
<input type="checkbox"/> 01 Face (explain)	<input type="checkbox"/> 01 Wounds (cuts)	<input type="checkbox"/> Hospitalized
<input type="checkbox"/> 02 Toe or foot R L	<input type="checkbox"/> 02 Hernia	<input type="checkbox"/> Emergency hospital care
<input type="checkbox"/> 03 Internal organs (not lungs)	<input type="checkbox"/> 03 Fracture	<input type="checkbox"/> First Aid Provided by whom: <input type="text"/>
<input type="checkbox"/> 04 Fingers	<input type="checkbox"/> 04 Dermatitis	<input type="checkbox"/> Doctor's care
<input type="checkbox"/> 05 Hands R L	<input type="checkbox"/> 05 Strain	<input type="checkbox"/> Time loss
<input type="checkbox"/> 06 Arms R L	<input type="checkbox"/> 06 Sprain	<input type="checkbox"/> Same day time loss Time left work <input type="text"/>
<input type="checkbox"/> 07 Trunk	<input type="checkbox"/> 07 Contusion (bruise)	<input type="checkbox"/> No time loss
<input type="checkbox"/> 08 Lungs	<input type="checkbox"/> 08 Burns	<input type="checkbox"/> Employee returned work? YES <input type="checkbox"/> NO <input type="checkbox"/>
<input type="checkbox"/> 09 Back	<input type="checkbox"/> 09 Foreign body	Date <input type="text"/>
<input type="checkbox"/> 10 Eyes R L	<input type="checkbox"/> 10 Infection	Time <input type="text"/>
<input type="checkbox"/> 11 Leg R L	<input type="checkbox"/> 11 Dislocation	
<input type="checkbox"/> 12 Knee R L	<input type="checkbox"/> 12 Chemical Exposure (Attach MSDS)	
<input type="checkbox"/> 13 Ankles R L	<input type="checkbox"/> 13 Infectious Exposure (explain)	
<input type="checkbox"/> 14 Shoulders R L	<input type="checkbox"/> 14 Other <input type="text"/>	
<input type="checkbox"/> 15 Head		
<input type="checkbox"/> 16 Neck		
<input type="checkbox"/> 17 Groin		
<input type="checkbox"/> Other <input type="text"/>		

Treating Physician Name Hospital

Physician's Address Doctor's instructions Physician's Phone #

Any person who willfully makes a false statement or representation for the purpose of obtaining any benefit or payment under the provisions of this chapter, either for himself or any other person, shall be guilty of a felony. (N.R.S. 616.675)

Supervisor's Investigation* Employee's signature Date

Supervisor's signature Date

Safety Rep's comments* Safety Rep's signature Date

*Use additional sheets if necessary.

Reports shall be completed and distributed in accordance to Safety & Health Procedures Manual, Chapter 1-Safety Administration, SHP-115 Occupational Injury/Illness Reporting.

My Employer/insurer may have 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 "Claim for Compensation (Form C-4)" on reverse side.

For assistance with Workers' Compensation Issues you may contact the Office of the Governor Consumer Health Assistance
 TOLL FREE: 1-888-333-1597 Website <http://govcha.state.nv.us> E-mail: cha@govcha.state.nv.us

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

ADDITIONAL INFORMATION

Use this sheet if additional space is needed.

OCCUPATIONAL/INJURY CHECKLIST

- Inform your on-duty supervisor **immediately**.
- If you believe a blood-borne exposure has occurred, call 702 267-4911 and ask for the Battalion Chief on duty.**
- Apply first aid treatment, if necessary **OR** seek medical treatment at one of the approved medical facilities listed below (within 90 days of the date of the injury/illness; however, within 30 days is recommended).
- Keep a copy of all documentation for your personal records.
- Contact your supervisor after each doctor's visit regarding your physician's recommendations. If you have been released to full duty, you will need to return to work. If you have been released to modified duty, you will need to return to work and coordinate your new light-duty work (if available) with your supervisor. If your doctor has taken you completely off work, please contact your supervisor with notification of the physician's recommendations. **Only the treating physician may address work status and restrictions.**

IF TREATMENT IS RENDERED, THE FOLLOWING FORMS MUST BE FAXED AS SOON AS POSSIBLE TO RISK MANAGEMENT AT 702-267-1902, AND FOLLOWED UP WITH HARDCOPIES INTEROFFICED TO MSC 127:

- "Employee's Claim for Compensation/Report of Initial Treatment" (C-4)** form provided by the treating physician's office on the initial visit - *NOTE: please include all your contact telephone numbers and home address. Claims will not be initiated if the C-4 is incomplete or unsigned. (The insurer is the City of Henderson; the Third Party Administrator is CCMSI). Please be sure to get a copy of the C-4 from the medical provider on your initial visit. Your claim cannot be processed without one.*
- "Workers' Compensation Accident/Injury Treatment Report" (T-1)** form is to be completed by your physician/specialist at every office visit, signed by the physician/specialist, you, and your supervisor. Forward original to HR – Risk Management as soon as possible. (The approved medical facilities have a supply on site; emergency rooms may or may not have this form.)
- "Supplemental Information"** form - *NOTE: only complete this form if you are NOT a current City of Henderson employee.*
- "Witness Report"** to be completed by all witnesses to the injury/illness

IF APPLICABLE, THE FOLLOWING FORMS ARE ALSO COMPLETED, FAXED AND INTEROFFICED:

- "Vehicle Accident Report Kit"**, if applicable (located in all City vehicles)
- If a Police Report was filed, please include a copy of the report (or Police Report number).

APPROVED MEDICAL FACILITIES

- **Center for Occupational Health & Wellness** *Hours: 8:00 a - 4:00 p, M-F
9005 S. Pecos, Suite 2600, Henderson, NV 89074, Phone: (702) 474-0472
 - **Concentra Medical Center** *Hours: 8:00 a to 5:00 p, M-F
149 N. Gibson, Suite H, Henderson, NV 89014, Phone: (702) 558-6275
 - **Joseph W. Johnson, M.D., LTD.** *Hours: 8:00 a – 5:00 p. M-F; (except Thursday afternoon)
106 E. Lake Mead Parkway, Suite 104, Henderson, NV 89015, Phone: (702) 565-8911
- *Center hours above subject to change. Please call ahead if you would like to verify that the facility is open.*
- **Concentra Medical Center** – OPEN 24 HOURS/7 DAYS A WEEK (after-hours care only)**
5850 Polaris Ave, Suite 100, Las Vegas, NV 89118, Phone: (702) 739-9957 ***To be used for initial visit only*
 - **On-Site Health & Safety 24 Hours/ 7 days a Week** (866) 998-2750 Call and they will come to the job-site for treatment

In case of an emergency, please go to St. Rose Hospital - Rose de Lima Campus, St. Rose Dominican Hospital - Siena Campus OR the nearest emergency room/hospital.

CONTACTS

CCMSI is the third party administrator (TPA) that has been contracted by the City of Henderson to administer its self-funded workers' compensation program. The TPA provides claims management to ensure quality benefit delivery for employees injured on the job or suffering from occupational disease.

CCMSI:

- **Julie Vacca, Claims Supervisor**
Phone: (702) 933-4821; Fax: (217) 477-3023
- **Susan Riccio, Claims Representative**
Phone: (702) 933-4804; Fax: (217) 477-3028
- **Candice Egan, Medical Only Claims Representative**
- Phone: (702) 933-4805

Any specialized care will be referred by your treating physician and MUST be pre-approved by CCMSI.

CCMSI will use a provider from the current Workers' Compensation Provider Directory. For further information, please review the electronic version of "*Your guide to: Workers' Compensation...know the facts*" located in the Human Resources Document Library on the City of Henderson's Intranet.

CITY OF HENDERSON:

- **Mary Sexton, Workers' Compensation Analyst** Phone: (702) 267-1922

This checklist highlights the important, initial steps to take in the event of an on-the-job injury/illness. It is not intended to be all-inclusive of the processes/procedures related to workers' compensation. If you have specific questions, please refer to the Guide or contact any of the individuals listed above.