Personnel Plus

413 W. Second St., Carson City, NV 89703
Phone: 775-350-7587
Fax: 775-350-7590

Report *ALL* on-the-job injuries to:

Personnel Plus
Phone: 775-350-7587
Fax: 775-350-7590

All required injury reporting forms are contained within this packet.
These forms are also available at www.ppstaffing.org

Rev 04/16

Personnel Plus, Inc.
Direct Placement of
General, Professional, Medical, & Dental

418 W. Second St., Carson City, NV 89703
Ph: 775-350-7587 Fax: 775-350-7590

Report ***ALL*** **on-the-job** incidents, accidents and/or injuries

IMMEDIATELY TO

Personnel Plus
CALL 775-350-7587

Timely reporting of the incident, accident or injury is critical for ensuring deadlines are met for filing the reports as described within the State of Nevada Statutes and OSHA Regulations.

Upon notification of the incident, accident or injury **ensure** the following forms are completed and forwarded to
PERSONNEL PLUS.

Employee Report of Injury

This form is to be filled out by the injured employee.

Direct Supervisor's Report of Injury

This form is to be filled out by the Direct Supervisor.

Witness Statement

This form is to be completed by any witnesses to the accident.

Notice of Injury or Occupational Disease C-1 (Incident Report)

This form must be completed and signed by the injured employee and the Direct Supervisor. The employee should retain a copy for his/her records.

Brief Description of Rights and Benefits

This form is to be provided to the injured employee's records.

If you need assistance in completing these forms, please contact:

Personnel Plus
Phone 775-350-7587 FAX 775-350-7590

AFTER ALL FORMS HAVE BEEN COMPLETED, FAX THEM TO 775-350-7590

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EMPLOYEE REPORT OF INJURY

This form must be completed by the injured employee and reviewed and signed by the Supervisor.
Please type or print legibly.

Name:_____ Date of this Report:_____

Home Address:_____
(Street, City, State, Zip Code)

Social Security Number:_____ Home Phone Number:_____

What was your job position at the time of your injury?:_____

How long have you been working at this position?:_____ Is this your regular position?_____

Date of injury:_____ Day of week:_____ Time of day:_____ AM___ PM___

Did the injury occur on your regular shift? _____ If "no" please explain:_____

Date you reported injury to supervisor: _____ Name of Supervisor:_____

Where did this injury occur?_____
(list specific worksite, facility or other location)

List any equipment, machine, tool, substance, or condition that may have contributed to the injury: _____

Were you wearing appropriate safety equipment at the time of injury?_____ (YES or NO)

If "NO" please explain _____

Did you or anyone else do (or fail to do) anything that may have contributed tot he injury? _____ (YES or NO)

If "YES" Please explain: _____

DID YOU REQUEST MEDICAL ATTENTION OTHER THAN FIRST AID? _____ (YES or NO)

If "NO" please explain why you did not seek medical attention: _____

If "YES", please list the name of the treating physician and phone number:_____

What type of injury did you have? (Burn, Cut, Fracture, etc.):_____

What part(s) of your body were injured? (Left hand, right leg, chest, etc.):_____

I certify that by my signature below that the statements I have made on this report are true and correct. I further certify that I have made these statements of my own free will without prompting, influence, or persuasion.

_____ Date_____
Signature of employee completing this report

_____ Date_____
Signature of employee's Supervisor

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DIRECT SUPERVISOR'S REPORT OF INJURY

(To be completed by the injured workers' direct supervisor or person in charge at the time of incident.)

Employee's Name:_____ Social Security No:_____ Home Phone:_____

Employee's Address: _____
(Street, City, State, Zip Code)

Job Position:_____ Was this the employee's normal job position? Yes ___ No___

Date:_____ Time of Incident: _____ AM/ PM Date **NOTIFIED** of the incident: _____

Name of Business/ facility where incident occurred:_____

Address:_____
(Street, City, State, Zip Code)

Name of attending clinic/ treatment center/ physician and phone #:_____

Describe how the employee was injured: (attach a second sheet, drawing or sketch if needed) _____

List any MACHINE, EQUIPMENT, SUBSTANCE, or CONDITION that contributed to the incident: _____

Did the injured DO or Fail TO DO anything that might have contributed to the injury/ (If Yes, Explain):_____

List any witnesses and their phone number to the incident: _____

Injured Body Part(s) (circle r=right, l=left):

Ankle	R/ L	Knee	R/ L	Neck
Buttocks	R/ L	Lower Leg	R/ L	Chest
Ear	R/ L	Upper Leg	R/ L	Head
Elbow	R/ L	Toe	R/ L....Big.....Second.....Middle.....Fourth.....Little (Circle Applicable)	
Eye	R/ L	Fingers	R/ L....Thumb....Index....Middle....Ring....Little (Circle Applicable)	
Hand	R/ L	OTHER:_____		

How many days per week does employee work?_____ From _____ AM/PM to _____ AM/PM

Last day wages were earned: _____ Are you paying injured employee's wages during disability? _____ (YES or NO)

Scheduled days off (check appropriate): ___ Sun ___ Mon ___ Tues ___ Wed ____ Thur ___ Fri ___ Sat ___ Rotating

Last day of work after injury: _____ (Date) Date of return to work: _____ # of days lost: _____

Was the employee hired to work 40 hours per week? _____ (YES or NO) Does injured worker speak English? _____

Additional comments or statement in regards to this report: _____

_____

_____

_____ Date: _____
Signature of Supervisor completing this report

FAX TO 775-350-7590 - Personnel Plus

(Rev 10/15)

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WITNESS STATEMENT

This form must be completed by the **WITNESS** - not the injured employee. Type or print legibly.

Witness Name: _____ Witness Phone #: _____

Witness Address:_____
(Street, City, State, Zip Code)

Company Name:_____ (if other then injured employee's company)

Injured worker's name:_____

Date of incident:_____ Time: _____ AM/PM If known who did injury get reported to: _____

Where did injury occur? _____
(List Physical location or name of business, building, workstation, etc.)

Did you see incident occur? ____ (YES or NO) If no please continue with a description of what you did see.

Describe in detail how the injury occurred: _____

_____

_____

_____

Describe any equipment, substance, or condition that contributed to or caused the injury: _____

_____

Describe anything that the injured employee did or failed to do that contributed to the injury: _____

_____

What is your relationship to the injured worker? _____

How long have you known the injured worker? _____

List any other witnesses' that saw the injury occur:

Name: _____ Contact number: _____

Name: _____ Contact number: _____

Signature of Witness completing this report:_____ Date report completed: _____

FAX TO 775-246-7590 - Personnel Plus
(Rev 4/16

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

Name of Employer Personnel Plus Inc. 413 W. Second Street, Carson City, NV 89703

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 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

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

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