SAFETY COMMITTEE MEMBERS
Jim Caughron
Don Cavallo, Chairperson
Stacey Jackson
Margot Jordan
Tim Kay
Sheri Mendez
Todd Williams

LEGAL COUNSEL TO THE SAFETY COMMITTEE
David Watts-Vial

NOTICE OF MEETING AND AGENDA

WASHOE COUNTY SAFETY COMMITTEE

PUBLIC WORKS CONFERENCE ROOM, Washoe County Administration Complex
1001 E. Ninth Street, Building A, Room A255, Reno, Nevada

March 15, 2012
1:30 PM

NOTE: Items on the agenda may be taken out of order; combined with other items; removed from the agenda; moved to the agenda of another meeting; or may be voted on in a block.
The Washoe County Caucus Room is accessible to the disabled. If you require special arrangements for the meeting, call the Risk Management Office, 328-2071, 24-hours prior to the meeting.

Time Limits. Public comments are welcomed during the Public Comment periods for all matters, whether listed on the agenda or not, and are limited to two minutes per person. Persons are invited to submit comments in writing on the agenda items and/or attend and make comment on that item at the Safety Committee meeting. Persons may not allocate unused time to other speakers.

Forum Restrictions and Orderly Conduct of Business. The Safety Committee conducts the business of Washoe County and its citizens during its meetings. The presiding officer may order the removal of any person whose statement or other conduct disrupts the orderly, efficient or safe conduct of the meeting. Warnings against disruptive comments or behavior may or may not be given prior to removal. The viewpoint of a speaker will not be restricted, but reasonable restrictions may be imposed upon the time, place and manner of speech. Irrelevant and unduly repetitious statements and personal attacks which antagonize or incite others are examples of speech that may be reasonably limited.

Responses to Public Comments. The Safety Committee can deliberate or take action only if a matter has been listed on an agenda properly posted prior to the meeting. During the public comment period, speakers may address matters listed or not listed on the published agenda. The Open Meeting Law does not expressly prohibit responses to public comments by the Safety Committee. However, responses from the Safety Committee to unlisted public comment topics could become deliberation on a matter without notice to the public. On the advice of legal counsel and to ensure the public has notice of all matters the Safety Committee will consider, the Safety Committee may choose not to respond to public comments, except to correct factual inaccuracies, ask for County staff action or to ask that a matter be listed on a future agenda. The Safety Committee may do this either during the public comment item or during the following item: "Topics for Future Agendas".

Pursuant to NRS 241.020, the Agenda for the Washoe County Safety Committee Meeting has been posted at the following locations: Washoe County Administration Building (1001 E. 9th Street, Bldg. A), Washoe County Courthouse-Clerk's Office (Court and Virginia Streets), Washoe County Central Library (301 South Center Street); Sparks Justice Court (630 Greenbrae Drive).

Support documentation for the items on the agenda, provided to the Washoe County Safety Committee is available to members of the public at the Risk Management Office (1001 E. 9th Street, Bldg. A, 2nd Floor, Room A225, Reno, Nevada).

All items numbered below are hereby designated **for possible action** as if the words "for possible action" were written next to each item (NRS 241.020). An item listed with asterisk (*) next to it is an item for which no action will be taken.

1:30 p.m.

1. * Roll Call

2. * Public Comment. Comment heard under this item will be limited to two minutes per person and may pertain to matters both on and off the Safety Committee agenda. The Safety Committee will also hear public comment during individual action items, with comment limited to two minutes per person. Comments are to be made to the Safety Committee as a whole.

3. Approval of the agenda for the Washoe County Safety Committee meeting of March 15, 2012.

4. Approval of the Washoe County Safety Committee meeting minutes of September 15, 2011.

5. Election for new Safety Committee Chairperson.

6. Industrial Injury Reviews

    - Laura Ash, Comptroller's Office
    - Mia Bosetti, Juvenile Services
    - Brandon Christensen, Roads Division
    - David Dunham, Sheriff's Department
    - Ron Encinas, Sheriff's Department
    - David Morris, Equipment Services Division
    - Clint Player, Sheriff's Department
    - Janis Vinci, Animal Services Division
    - Michael Yonker, Sheriff's Department

7. Washoe County's AEDs and First Aid Kits: Report and discussion lead by Jim Caughron.

8. Topics for future agendas.

9. * Public Comment. Comment heard under this item will be limited to two minutes per person and may pertain to matters both on and off the Safety Committee agenda. The Safety Committee will also hear public comment during individual action items, with comment limited to two minutes per person. Comments are to be made to the Safety Committee as a whole.

10. Adjournment.

FINANCE DEPARTMENT
Risk Management Division
- *Safety*
- *Insurance*

WASHOE COUNTY
"Dedicated to Excellence in Public Service"

1001 E. Ninth Street
P.O. Box 11130
Reno, Nevada 89520-0027
Phone: (775) 328-2071
Fax: (775)-328-2094

SAFETY COMMITTEE MEETING MINUTES OF SEPTEMBER 15, 2011

The Washoe County Safety Committee Meeting convened at 1:43 p.m. in regular session in the HR Large Conference Room, Washoe County Administration Complex, 1001 E. Ninth Street, Building A, Room A210, Reno, Nevada.

1. Roll Call.

Chairperson Don Cavallo called the meeting to order. Members present were:
Chairperson Don Cavallo, Deputy Todd Williams, Stacey Jackson, and Jim Caughron

Legal Counsel to the Committee present was:
David Watts-Vial

2. Public comment.

Agenda Subject: "Public Comment. Comment heard under this item will be limited to two minutes per person and may pertain to matters both on and off the Safety Committee agenda. The Safety Committee will also hear public comment during individual action items, with comment limited to two minutes per person. Comments are to be made to the Safety Committee as a whole."

There was no response to the call for public comment.

3. Approval of the agenda for Washoe County Safety Committee meeting of September 15, 2011.

There was no response to the call for public comment.

On motion by Mr. Caughron, seconded by Mr. Williams by which motion duly carried, it was ordered that the agenda be approved.

4. Approval of the Washoe County Safety Committee meeting minutes of July 21, 2011.

There was no response to the call for public comment.

On motion by Mr. Caughron, seconded by Ms. Jackson by which motion duly carried, it was ordered that the minutes be approved.

5. Industrial Injury Review

Pursuant to County code 65.150, an employee who loses time from work is required to go before the Safety Committee. The Industrial Injury Review is not meant to discuss the person's medical records, discipline or character. The review is to find out only how the injury occurred and how it can be prevented.

a. Mary Encarnacion-Miller, Social Services Department

Mary Encarnacion-Miller arrived for her review. Stephen Shipman from Social Services Administration was present to answer any questions the committee had.

Ms. Encarnacion-Miller was diagnosed with carpal tunnel syndrome on August, 24, 2010. In February 2011 she had surgery. She still has carpal tunnel and wears a brace. She modified her work station, wears a headset, uses an ergonomic keyboard and uses an adjustable keyboard tray.

Mr. Caughron made a motion to assess Ms. Encarnacion-Miller's work station to ensure it is ergonomically correct. Ms. Jackson seconded the motion and the motion was passed.

Mr. Cavallo thanked Ms. Encarnacion-Miller and Mr. Shipman for their time and for participating in the interview.

b. Deputy Mark McNeil, Sheriff's Department

Deputy Mark McNeil arrived for his review. Sergeant Kandi Payne-Davis was present to answer any questions the committee had.

Deputy McNeil was on a raised platform in the Area Control 4 Rotunda area putting away a TTY phone he retrieved for an inmate. When he turned to descend down the steps, he tripped and twisted his left knee.

Deputy Williams asked if anyone has inspected those stairs for proper width and height because it is his understanding that Deputy McNeil is not the first person who fell from that platform. Mr. Williams made a motion to have Mr. Caughron inspect the steps and platform for correct height and width. Mr. Caughron seconded the motion. Motion was approved.

Mr. Cavallo thanked Deputy McNeil and Sergeant Payne-Dave for their time and for participating in the interview.

c. Kimberly Oates, Washoe County District Court

Kimberly Oates arrived for her review. Angela Davis was present to answer any questions the committee had.

Ms. Oates parked in her assigned parking spot. She walked down the stairs in the parking gallery and walked across the bridge to the courthouse. While walking to work, she slipped, fell, and broke her elbow. Mr. Cavallo said that the City of Reno is supposed to keep those areas clear. Ms. Oates said she actually saw a backhoe in the area on the sidewalk taking care of things, but everything was frozen.

Mr. Cavallo thanked Ms. Oates and Ms. Davis for their time and for participating in the interview.

d. Larry O'Connell, Building and Safety Department

Larry O' Connell arrived for his review. Don Jeppson was present to answer any questions the committee had.

Mr. O'Connell brought an aerial photo of the area where the accident occurred. It showed the house in Incline Village where he was to perform a building inspection. It was January 11, 2011 and there was about 3 feet of snow on the ground from the previous days. About 10 a.m. he pulled up to the job site. There was no driveway or pathway leading to the house from the street. He parked the truck and got out of the truck. He saw black ice and steadied himself. As he was closing the door, he slipped on the ice, fell, and broke his shoulder.

Mr. Jeppson added some additional information. Their department deals with some sort of injury every year up in Incline. Construction jobs are hazardous anyways and more so in the winter with ice and snow. They have a policy in place that if an inspector does not feel safe (within reason); they can refuse inspection that day. It is their judgment call. The department also has available snow grippers for employees to use on their shoes, although they have found that on steeper or uneven terrain, the grippers do not work. Mr. O'Connell moved to Reno from Tahoe in 1975, so he is very familiar with what protective footwear and clothing to wear.

Mr. Cavallo thanked Mr. O'Connell and Mr. Jeppson for their time and for participating in the interview. Mr. Cavallo made the aerial photo a part of the record.

6. Parks Department's winter months water schedule: Follow-up report by Jim Caughron

Mr. Caughron spoke with Al Rogers from the Parks Department. Mr. Rogers said that the water was shut off at that particular park when and where that injury occurred. The Parks Department shuts the water off at the beginning of the winter season every year; otherwise the pipes will freeze and break. Mr. Rogers said there was a good possibility that the morning dew froze, which created a layer of ice.

There was no response to the call for public comment.

7. Incline Village Substation snow removal services:

Mr. Caughron spoke with Dave Solaro about the snow removal problems we had last year. Mr. Solaro guaranteed that it is going to be better this year, as they increased their budget for better snow removal services.

Mr. Caughron also spoke with Dick Minto with the Roads Department in Incline Village. Mr. Minto goes to the Sheriff's substation and clears as much snow as possible. The problem is that the road is tilted towards the building, and this creates a gully where snow builds up and freezes. The employee parking area is left up to the employees to put ice melt out.

Mr. Cavallo said there are snow melt bags located at his building, and he assumes that it is up to the employees to spread it when necessary. Mr. Caughron said the County used to have the Parks Department do this, but then an outside landscape contractor was hired instead. Mr. Cavallo brings his own shovel to clear the snow because by the time they come around to clear their building, it is two o'clock in the afternoon.

There was no response to the call for public comment.

8. Other possible safety training classes for the Health Department's nursing staff: Report by Deputy Todd Williams

Deputy Williams spoke with Sergeant Sandra Barboza in the WCSO training department. She said the nursing staff can email their request as to what type of training they would like, and they'll see if they can put something together. They do not specifically have this type of training program set up, but she will see what she can put together and have someone from the Sheriff's Office go out and speak to the nurses. Sergeant Harry Dixon used to do this, but he retired.

Mr. Caughron said that the County is required by OSHA to do their best to keep employees safe. Mr. Caughron will contact OSHA to see if he can get more safety information, and then meet with Deputy Williams and Sergeant Barboza.

In response to public comment, Stacy Hardie from the Health Department said that she will check with the Social Services Department, Senior Services and the Public Guardian's Office to see if they have anything in place that would help their department. Ms. Hardie said they are also considering purchasing safety booklets to give to their staff.

9. Teleconferencing the Industrial Injury Review Interviews: Legal opinion by David Watts-Vial and Safety Committee to discuss whether or not to keep the process or make changes.

Mr. Cavallo's main concern is that so many people are taken out of their work environment to attend these Safety Committee meetings. In reviewing the County Codes, it can be interpreted that the committee could review the incidents and make a decision as to whether or not they need to call the employee to be interviewed at the next safety meeting.

Ms. Jackson stated it would be helpful in the preview meeting to get an email from the employee with a more detailed explanation of the employee's accident. Mr. Caughron advised he can add information about the accident at the preview meeting because he deals with the employee and knows their case.

Mr. Watts-Vial said that Mr. Cavallo accurately recited the provisions of the code. He said that everyone can meet and it will be properly noticed. The committee reviews the reports and determines if an employee needs to be further interviewed or if further evaluations are needed. That would include getting an email from the employee, but he recommends that the email should only be sent to Mr. Caughron, so that it doesn't violate the open meeting law. Mr. Cavallo suggested that the email be sent to Mr. Caughron and for it to be part of the package that will be forwarded to the committee members to review in preparing for the safety meeting.

There was no response to the call for public comment.

Mr. Caughron made a motion that the industrial injury cases be reviewed by the committee members at the next meeting to determine if the employee needs to be interviewed in person by the committee. Ms. Jackson seconded the motion. Mr. Cavallo said there is no harm in trying this new process, and if they don't like it they can change it back or discuss if they need to go in a different direction. If the committee does it this way, a lot of personnel time and productivity is saved. It was ordered that the motion be approved.

10. Safety Committee Meetings – employees being informed via County's newsletter: Follow-up report by Jim Caughron.

Mr. Caughron asked Chris Matthews to publish information about the Safety Committee meetings on the County's Flipside, but he could not locate it when he went on-line. He will call Mr. Matthews to find out where he placed it on the Flipside.

Mr. Caughron sent an email to the HR Representatives and Department Heads advising when the Safety Committee meets and that the committee is taking safety suggestions. He advised the committee that he has a lot of safety tips to share with employees and that he can share these tips via email. Deputy Williams suggested that once a month should be sufficient and Ms. Jackson agreed.

There was no response to the call for public comment.

Mr. Caughron made a motion to email the HR Representatives and Department Heads safety tips once a month. Deputy Williams seconded the motion and the motion was approved. Mr. Cavallo thanked Mr. Caughron for everything he does, not only for the committee but for the entire County.

11. Items to be discussed for future agendas.

There was no response to the call for public comment.

No items at this time. Mr. Caughron recommended that committee members email Carol Smith with agenda items for the next meeting.

12. Public Comment

Agenda Subject: "Public Comment. Comment heard under this item will be limited to two minutes per person and may pertain to matters both on and off the Safety Committee agenda. The Safety Committee will also hear public comment during individual action items, with comment limited to two minutes per person. Comments are to be made to the Safety Committee as a whole."

Stacy Hardie, from the Health Department, wanted to add that not only are the nurses in the field at risk, but also their department staff is at risk. She represents their division in the Department Emergency Management Committee which is meeting next week. This is an agenda item for their meeting as well.

They had a recent incident with a threatening client, and they had to contact the police department to remove him from the premises. The staff felt very threatened. It took a while for the police to respond, but luckily no one was harmed.

Ms. Hardie said that one of her concerns is that their environment is so incredibly open and people can wander around in the hallways. She wanted to know if the County can perform walk-through safety assessments of the various buildings in the County. She feels this issue affects other departments. Mr. Cavallo advised her that since this is public comment, the committee cannot address this issue at this time or make a recommendation. Mr. Cavallo thanked Ms. Hardie for her comment.

Mr. Caughron received an email with a safety suggestion from an employee. The employee suggested that the employee parking lot and the employee walk-way paths to the buildings be de-iced. He explained to the employee that the County does the best they can with the funds they have, but they do no have the funds to do what she suggested.

13. Adjournment - 2:25 p.m.

There being no further business to come before the committee, on motion by Mr. Caughron and seconded by Ms. Jackson with no opposition by members, Mr. Cavallo ordered that the meeting be adjourned.

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

RECEIVED JUL 27 2011 W.C.S.O. PAYROLL

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
WASHOE COUNTY	LAW ENFORCEMENT		139/11

Office Mail Address	Location . . . If different from mailing address	Telephone
911 PARR BLVD	3101 LONGLEY, RENO NV	(775) 328-3026

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
RENO	NV	8951		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
MICHAEL	A	YONKER	[redacted]	4-21-74	37	English

Home Address (Number and Street): [redacted]

Sex ☒ Male ☐ Female | Marital Status ☐ Single ☐ Married ☒ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
RENO	NV	89523	☒ Yes ☐ No	11 ½ YEARS

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Deputy Sheriff	Patrol

Telephone	Is the injured employee a corporate officer?	. . . sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
7-22-11	1725 (5:25 pm)	7-22-11	SGT. BILL DEVINE

Address or location of accident (Also provide city, country,state) (if applicable): 2055 HWY 410 VERDI, NV.

Accident on employer's premises? (if applicable) ☐ Yes ☒ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)
TAKING PHYSICAL CONTROL OF A RESISTING SUSPECT

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.
ON 7-22-11 @ APPX 1725 HYS. DEPUTY YONKER WAS PREPARING TO HANDCUFF GABE LUSK. LUSK BEGAN TO PULL AWAY AND TURN TOWARDS YONKER. YONKER PLACED LUSK IN A HEADS LOCK AND TURNED & TOOK LUSK TO THE GROUND. YONKER TWISTED HIS LEFT KNEE AND LANDED ON IT. KNEE BEGAN TO SWELL.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable): HANDS ON

Witness: SGT. BILL DEVINE

Was there more than one person injured in this accident? (if applicable) ☐ Yes ☒ No

Part of body injured or affected	If fatal, give date of death	Witness
LEFT KNEE	N/A	

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.): TWISTING OF LEFT KNEE

Witness:

Did employee return to next scheduled shift after accident? (if applicable) ☒ Yes ☐ No

Will you have light duty work available if necessary? ☒ Yes ☐ No

RECEIVED JUL 28 2011 WASHOE COUNTY RISK MANAGEMENT DIVISION

If validity of claim is doubted, state reason: N/A

Location of Initial Treatment: N/A

Treating physician/chiropractor name: NONE

Emergency Room ☒ Yes ☐ No | Hospitalized ☐ Yes ☒ No

IMPORTANT

How many days per week does employee work? 4

From 2:00 ☐ am ☒ pm To 12:00 ☒ am ☐ pm

Last day wages were earned: 7-22-11

Scheduled days off: S ☒ M ☒ T ☐ W ☐ T ☐ F ☐ S ☒ Rotating ☐

Are you paying injured or disabled employee's wages during disability? ☒ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
01-20-2000	7-22-11	UNKNOWN	NONE SO FAR

Was the employee hired to work 40 hours per week? ☒ Yes ☐ No

If not, for how many hours a week was the employee hired?

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☒ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more . Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☒ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☒ BI-WKLY ☐ SEMI-MONTHLY	$ 29.33 per ☒ Hr ☐ Day ☐ Wk ☐ Mo

500 / 6 = 1500 / 1512

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title: [signature] | Date: 7/27/11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

RECEIVED
JUL 27 2011
W.C.S.O.
PAYROLL

RECEIVED
JUL 28 2011
WASHOE COUNTY
RISK MANAGEMENT DIVISION

Name of Employer WASHOE COUNTY

Name of Employee	Social Security Number	Telephone Number
MICHAEL YONKER	[redacted]	775 [redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
7-22-11	1725	2055 HWY 40 VERDI, NV

What is the nature of the injury or occupational disease?	List any body parts involved:
STRAINED LEFT KNEE	LEFT KNEE

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)

DEP. YONKER INSTRUCTED SH GABE LUSK TO PLACE HIS HANDS BEHIND HIS BACK. LUSK PULLED AWAY & TURNED TOWARDS YONKER. YONKER PLACED LUSK IN A HEADLOCK & SPUN HIM TO THE GROUND. YONKER TWISTED HIS LEFT KNEE IN THE PROCESS.

Names of witnesses:

SGT BILL DEVINE

Did the employee leave work because of the injury or occupational disease?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
___ YES X NO		X YES ___ NO	7-22-11 SAME

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
~~X~~ ~~YES~~ ~~X NO~~	~~N/A~~ DR. INDA	~~N/A~~ RENOWN SOUTH ER

Did the accident happen in the normal course of work? (if applicable) X YES ___ NO

Was anyone else involved?	Names of others involved
___ YES X NO	

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.

411 — 7-22-11

Supervisor's Signature — Date

M YONKER PER B 411

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

C-1 (Rev. 10/07)

EMPLOYEE'S CLAIM FOR COMPENSATION/ REPORT OF INITIAL TREATMENT 0419000
FORM C-4

540226966

EMPLOYEE'S CLAIM - PROVIDE ALL INFORMATION REQUESTED

First Name	Last Name	Birthdate	Sex		Claim Number
Michael	Yonker	4/21/1974	male		
Employee Address [redacted]		Age 37 y.o.	Height 6' 2" (188 cm)	Weight 99.791 kg	SSN xxx-xx[redacted]
City Reno		State Nevada	Zip 89523		Telephone [redacted]
Insurer / Third Party Administrator N/A		Employee's Occupation Deputy Sherrif			
Employer's Name WASHOE COUNTY JAIL/COURTS		Telephone 775-328-6348			
Employer Address 911 PAIR BLVD		City RENO	State Nevada [29]		Zip 89506

Date of Injury	Hour of Injury	Date Emp Notified	Last Day Worked	Supervisor
7/22/2011	5:25 PM	7/22/2011	7/22/2011	Sargent Bill Devine

Address or Location of Accident
911 PAIR BLVDRENONevada [29]89506

What were you doing at the time of accident?
Dep Yonker instructed suspect 1 Gabe Lusk to place his hands behind his back, Lusk pulled away & turned towards Yonker. Yonker placed Lusk in a headlock & spun him to the ground. Yonker Twisted his left knee in the process.

How did this injury or occupational disease occur?
Dep Yonker instructed suspect 1 Gabe Lusk to place his hands behind his back, Lusk pulled away & turned towards Yonker. Yonker placed Lusk in a headlock & spun him to the ground. Yonker Twisted his left knee in the process.

If you believe that you have an occupational disease, when did you first have knowledge of the disability and it relationship to your employment?	Witnesses to the Accident
NA	Sargent Bill Devine

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
Strain	Knee (L), N/A, N/A

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 other person, any hospital, including Veterans Administration or government 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 Signature
7/22/11	Renown So. Meadows	[signature]

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

Place	Name of Facility
RENOWN SOUTH MEADOWS MEDICAL CENTER, EMERGENCY DEPT	Renown

Date	Diagnosis	Is there evidence the injured employee was under the influence of alcohol and/or another controlled substance at the time of accident?
7/22/2011	844.9	No
Hour 12:17 AM	Description of Injury or Disease The encounter diagnosis was Strain of knee and leg, left.	

Treatment	Have you advised the patient to remain off work five days or more?		
Splint, crutches	No		
X-Ray Findings	If Yes	From Date	To Date
Negative			

From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred?	If No	Full Duty	Modified Duty
Yes		No	Yes
Is additional medical care by a physician indicated? Yes	If Modified Duty, Specify any Limitations / Restrictions Weight bear as tolerated on left lower extremity		

Do you know of any previous injury or disease contributing to this condition or occupational disease?
Yes
Comments:Prior ACL injury / repair

Date	Print Doctor's Name	I certify the employer's copy of this form was mailed on:
7/23/2011	Inda,Sven, M.D.	
Address 10101 Double R Blvd Reno NV 89521 775-982-7280		Insurer's Use Only RECEIVED JUL 25 11 CCMSI-RENO
City Reno	State NV / Zip 89521	
Provider's Tax ID Number 88-0213754	Telephone Dept: 775-982-7144	
Doctor's Signature e-Sign INDA, SVEN M.D.	Degree	

Original–Treating Physician or Chiropractor Page 2–Insurer/TPA Page 3–Employer Page 4–Employee

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County	GOVT		

Office Mail Address	Location . . . If different from mailing address	Telephone
PO Box 11130	1001 9th St. Reno NV	

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
Reno	NV	89520		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Janis	M.	Vinci	[redacted]	9-9-1958	53	English

Home Address (Number and Street)	Sex	Marital Status
[redacted]	☐ Male ☑ Female	☐ Single ☑ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Reno	NV	89502	☑ Yes ☐ No	10 yrs

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Animal Control Officer	Public Works/Animal Svcs

Telephone	Is the injured employee a corporate officer?	. . . sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☑ No	☐ Yes ☑ No	☐ Yes ☑ No	☑ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
9-10-11	12:00 PM	9-10-11	Robert Smith

Address or location of accident (Also provide city, country, state) (if applicable)	Accident on employer's premises? (if applicable)
530 E Parrot Reno NV	☐ Yes ☑ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

Capturing a Stray dog

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

While attempting to capture a stray dog, Jan Vinci was knocked off her feet by the dog. She fell and fractured her face and broke her left arm

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable)
Snappy Snare	Jeff Kloehn	

Part of body injured or affected	If fatal, give date of death	Witness	
2 fractures of face, left arm broken		Jeff Kloehn	☐ Yes ☑ No

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	
2 fractures of face and broken left arm	Jeff Kloehn	

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Did employee return to next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
☐ Yes ☑ No	☑ Yes ☐ No

If validity of claim is doubted, state reason	Location of Initial Treatment
	Renown, Renown ER

Treating physician/chiropractor name	Emergency Room	Hospitalized
Kenyon E.R / Renown	☑ Yes ☐ No	☑ Yes ☐ No

IMPORTANT	How many days per week does employee work?	From	To	Last day wages were earned
	4	7:00 ☑ am ☐ pm	5:30 ☐ am ☑ pm	9-10-11

Scheduled days off	S	M	T	W	T	F	S	Rotating	Are you paying injured or disabled employee's wages during disability?
	☑	☐	☐	☐	☑	☐	☐	☐	☑ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
8-6-2001	9-10-11	?	?

Was the employee hired to work 40 hours per week?	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months?
☑ Yes ☐ No		☐ Yes ☑ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more . Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☑ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☑ BI-WKLY ☐ SEMI-MONTHLY	$21.93 per ☑ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title	Date
Office Supp Specialist	9-12-11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	**Date**	**Status Clerk**	**Date**

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

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

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RISK MANAGEMENT DIVISION

Name of Employer ANIMAL SERVICES

Name of Employee	Social Security Number	Telephone Number
JANIS VINCI		[redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
9-10-11	12:00	530 E PATRIOT

What is the nature of the injury or occupational disease?	List any body parts involved:
TWO FRACTURES TO FACE SEVERE BRUISE BROKEN LEFT ARM 12T HAND	FACE, LEFT ARM, Right HAND

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)
WHILE ATTEMPTING TO CAPTURE STRAY DOG, OFFICER WAS KNOCKED OFF OF HER FEET BY THE DOG. FELL AND FRACTURED FACE, BROKE LEFT ARM

Names of witnesses:
TORY KLOEHN

Did the employee leave work because of the injury or occupational disease?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
X YES ___ NO	12:00	___ YES X NO	

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
✓ YES ___ NO	REMSA RENOWNER	RENOWN SOUTH MEADOWS

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.

[signature] 9-10-11
Supervisor's Signature Date

NOT AVAILIMBLE
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

C-1 (Rev. 10/05)

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

EMPLOYEE'S CLAIM - PROVIDE ALL INFORMATION REQUESTED

First Name	Last Name	Birthdate	Age	Sex	Claim Number
Janis	Vinci	9/9/1958	53 y.o.	female	

Employee Address	Zip	Height	Weight	SSN
[redacted]	89502	1.727 m	83.915 kg	[redacted]

City	State	Zip	Telephone	Primary Language Spoken
Reno	Nevada	89502	[redacted]	Data Unavailable

Insurer / Third Party Administrator	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
N/A	control officer

Employer's Name	Telephone
WASHOE COUNTY SERV & EQUI	775-328-2124

Employer Address	City	State	Zip
2825LONGLEY LANE	RENO	Nevada [29]	89502

Date of Injury	Hour of Injury	Date Employer Notified	Last Day of Work after Injury or Occupational Disease	Supervisor to Whom Injury Reported
9/10/2011	12:30 PM	9/10/2011	9/10/2011	robert smith

Address or Location of Accident
2825LONGLEY LANERENONevada [29]89502

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WASHOE COUNTY
RISK MANAGEMENT DIVISION

What were you doing at the time of accident?
capturing dog fell hurting lft shoulder and face

How did this injury or occupational disease occur?
capturing dog fell hurting lft shoulder and face

If you believe that you have an occupational disease, when did you first have knowledge of the disability and it relationship to your employment?
capturing dog fell hurting lft shoulder and face

Witnesses to the Accident
joey kloehn

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
Dislocation	Shoulder (L), Facial Bones, N/A

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 other person, any hospital, including Veterans Administration or government 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 Signature
9/10/11	Renown SM	[signature]

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

Place	Name of Facility
RENOWN SOUTH MEADOWS MEDICAL CENTER, EMERGENCY DEPT	Renown

Date	Diagnosis	Is there evidence the injured employee was under the influence of alcohol and/or another controlled substance at the time of accident?
9/10/2011	812.20, , 802.4	No
Hour: 6:49 PM	Description of Injury or Disease: Diagnoses of Humerus fracture and Maxillary fracture were pertinent to this visit.	

Treatment	Have you advised the patient to remain off work five days or more?
In the emergency department the patient was given pain medication and her left arm is stabilized and she has been seen by the orthopedic surgeon who will plan surgery to repair a proximal left humerus fracture on an outpatient basis. I have also spok and en with Dr. Janiga who will see the patient for followup for multiple facial fractures. I have written her a prescription for Percocet for pain	Yes

X-Ray Findings	If Yes	From Date	To Date
Positive			

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

Is additional medical care by a physician indicated?	If Modified Duty, Specify any Limitations / Restrictions
Yes	The patient will not be able to work until after surgery and her work status will then be determined by Dr. Zebrack, her surgeon

Do you know of any previous injury or disease contributing to this condition or occupational disease?
No

Date	Print Doctor's Name	I certify the employer's copy of this form was mailed on:
9/10/2011	Paige,Todd E, M.D.	

Address	Insurer's Use Only
10101 Double R Blvd Reno NV 89521 775-982-7280	

City	State	Zip
Reno	NV	89521

Provider's Tax ID Number	Telephone
88-0213754	Dept: 775-982-7144

Doctor's Signature	Degree
e-Sign	

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

DEC 08 2009

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County Sheriff's Office	Law Enforcement		189/09

Office Mail Address	Location . . . If different from mailing address	Telephone
911 Parr Blvd		328-3001

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
Reno	NV	89512		W.C.S.O. PAYROLL

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Clint	N	Player	[redacted]	10/04/73	36	English

Home Address (Number and Street)	Sex	Marital Status
[redacted]	☐ Male ☐ Female	☐ Single ☒ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Sparks	NV	89436	☒ Yes ☐ No	13 years

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Deputy Sheriff	Patrol

Telephone	Is the injured employee a corporate officer?	. . . sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☒ No	☒ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
12/06/09		12/06/09	Sgt. Barnett

Address or location of accident (Also provide city, country, state) (if applicable)	Accident on employer's premises? (if applicable)
630 Woodpecker Ct Incline Village NV	☒ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

Walking

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

Employee began work at 07:00 AM, at approx. 15:15 hours employee responded to a call at 630 Woodpecker Ct. Incline Village, while walking towards the house employee slipped on ice and a ditch falling backwards

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable)
Ice, Snow	Deputy Gamboa	☐ Yes ☒ No

Part of body injured or affected	If fatal, give date of death	Witness
Right Elbow Shoulder/Neck Knee	N/A	

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	Did employee return to next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
Strain		☒ Yes ☐ No	☐ Yes ☐ No

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WASHOE COUNTY
RISK MANAGEMENT DIVISION

If validity of claim is doubted, state reason	Location of Initial Treatment
	Concentra - Sparks

Treating physician/chiropractor name	Emergency Room	Hospitalized
	☐ Yes ☒ No	☐ Yes ☒ No

IMPORTANT	How many days per week does employee work?	From	To	Last day wages were earned
	3 to 4	07:00 ☐ am ☐ pm	07:00 ☐ am ☒ pm	

Scheduled days off	S	M	T	W	T	F	S	Rotating	Are you paying injured or disabled employee's wages during disability?
	☐	☐	☒	☐	☒	☐	☐	☐	☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost

Was the employee hired to work 40 hours per week?	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months?
☐ Yes ☐ No		☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more. Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☒ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☒ BI-WKLY ☐ SEMI-MONTHLY	$ 29.74 per ☒ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title	Date
	12/9/09

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code

Claims Examiner's Signature	Date	Status Clerk	Date

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

RECEIVED
DEC 08 2009
W.C.S.O.
PAYROLL

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer WASHOE COUNTY SHERIFFS OFFICE

Name of Employee	Social Security Number	Telephone Number
CLINT PLAYER	[redacted]	[redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
12/06/09	1805	630 WOODRIDGE CI INCLINE VILLAGE NV

What is the nature of the injury or occupational disease?	List any body parts involved:
POSS. STRAIN R- KNEE R-ELBOW/SHOULDER/NECK	R. KNEE R-ELBOW/SHOULDER/NECK

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)
WHILE WALKING SLIP ON ICE IN A DITCH & FELL BACKWARDS ON TO R- WRIST & THEN BACK

Names of witnesses:
DEPUTY FRANK GAMBOA

Did the employee leave work because of the injury or occupational disease? ___ YES X NO	If yes, when (date and time)?	Has the employee returned to work? X YES ___ NO	If yes, when (date and time)? 12/07/09 0700 HRS
Was first aid provided? ___ YES X 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) X YES ___ NO			
Was anyone else involved? ___ YES X NO	Names of others involved NONE		

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DEC 10 2009
WASHOE COUNTY
RISK MANAGEMENT DIVISION

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 12-07-09

Signature of Injured or Disabled Employee — Date 12/07/09

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

C-1 (Rev. 10/05)

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	Claim Number (Insurer's Use Only)
CLINT	N	PLAYER	10/04/73	☒M ☐F	

Home Address	Age	Height	Weigh:	Social Security Number
[redacted]	36	5'10"	188	[redacted]

City	State	Zip	Telephone
SPARKS	NV	89436	[redacted]

Mailing Address	City	State	Zip	Primary Language Spoken
SAME				

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
		DEPUTY SHERIFF

Employer's Name/Company Name	Telephone
WASHOE COUNTY SHERIFFS OFFICE	328-3001

Office Mail Address (Number and Street): 911 PARR BLVD RENO NV 89512

Date of Injury (If applicable)	Hours Injury (If applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
12/06/09	06:05 am ☒pm	12/06/09	12/06/09	SGT BARRETT

Address or Location of Accident (If applicable): 630 WOODBRIDGE CI INCLINE VILLAGE

What were you doing at the time of the accident? (If applicable): RESPONDING TO A CALL

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
WHILE WALKING, I SLIPPED ON ICE INTO A DITCH. I FELL BACKWARDS. I ATTEMPTED TO STOP WITH MY RIGHT HAND LANDING ON MY WRIST THEN MY BACK.

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): DEPUTY A. GAMBOA

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
STRAIN	R. KNEE R. [illegible]/SHOULDER/WRIST

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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: Carson City Employee's 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?
12/7/09 0945	Contusion R knee, Strain R shoulder, Strain R wrist	☒No ☐Yes (If yes, please explain)

Treatment: ofc chiropractic, ice

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: WNL

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 Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
12/7/09	[illegible]	

Address		INSURER'S USE ONLY
255 Glendale Ave Ste#12		
City / State / Zip	Provider's Tax I.D. Number / Telephone	
Sparks, NV 89431	[illegible] 01-4828	
Doctor's Signature	Degree	
[signature]	DC	

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
B Washoe County	Government		

Office Mail Address	Location ... If different from mailing address	Telephone
PO Box 11130	3031 Longley Lane Reno, NV	775-328-2127

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
Reno,	NV	89520		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
David	L.	Morris	[redacted]	3/30/60	51	English

Home Address (Number and Street)	Sex	Marital Status
[redacted]	☑ Male ☐ Female	☐ Single ☑ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Sparks,	NV	89436	☐ Yes ☐ No	4 years

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Tube Truck Operator/Driver	Public Works-Equipment Svcs.

Telephone	Is the injured employee a corporate officer?	... sole proprietor?	... partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☑ No	☐ Yes ☒ No	☐ Yes ☒ No	☑ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
4/7/11	10AM	4/7/11	Tom Malleza

Address or location of accident (Also provide city, country, state) (if applicable)	Accident on employer's premises? (if applicable)
Lemmon Drive - Lemmon Valley	☐ Yes ☒ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

Fueling excavator in a drainage ditch.

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

On 4/7/11, at approximately 10 am, employee slipped on the snow while walking down the ditch and did the splits, falling against the bank of the ditch.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable)
Fuel truck	Bill Rosas	☐ Yes ☒ No

Part of body injured or affected	If fatal, give date of death	Witness
Right knee, Right & left groin, lower back	N/A	N/A

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	
Sprain and/or pull.		

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RISK MANAGEMENT DIVISION

Did employee return to next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
☑ Yes ☐ No	☑ Yes ☐ No

If validity of claim is doubted, state reason	Location of Initial Treatment
	Concentra-Greg St. Sparks

Treating physician/chiropractor name	Emergency Room	Hospitalized
Robert C. Erwin	☐ Yes ☒ No	☐ Yes ☒ No

IMPORTANT	How many days per week does employee work?	From	To	Last day wages were earned
	4	6 ☒ am ☐ pm	4:30 ☐ am ☒ pm	4/7/11

Scheduled days off	S	M	T	W	T	F	S	Rotating	Are you paying injured or disabled employee's wages during disability?
	☑	☐	☐	☐	☐	☐	☑	☐	☐ Yes ☒ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
4/16/07	4/8/11	4/8/11	0

Was the employee hired to work 40 hours per week?	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months?
☐ Yes ☐ No		☐ Yes ☑ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more. Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☒ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☒ BI-WKLY ☐ SEMI-MONTHLY	$ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title	Date
[signature] Risk Mgmt Svc.	4/8/11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

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Name of Employer WASHOE COUNTY

Name of Employee	Social Security Number	Telephone Number
DAVID MORRIS	[redacted]	[redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
4-7-11	10 AM	LEMMON VALLEY - LEMON DRIVE

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WASHOE COUNTY
RISK MANAGEMENT DIVISION

What is the nature of the injury or occupational disease?	List any body parts involved:
Pulled Pulled - STRAINED R+L GROIN - LOWER BACK - R-KNEE	R+L GROIN - LOWER BACK - R-KNEE

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)

WALKING DOWN THE BANK SLIPED IN SNOW DID THE SPLITS FELL BACK AGAINST THE BANK

Names of witnesses:
BILL ROJAS

Did the employee leave work because of the injury or occupational disease?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
X YES ___ NO	WENT TO DOCTOR + CAME BACK 4-7-11 1130A	X YES ___ NO	4-7-11 2P

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
___ YES X NO		CONCENTRA

Did the accident happen in the normal course of work? (if applicable)	Was anyone else involved?	Names of others involved
X YES ___ NO	___ YES X NO	

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 — 4-8-11 — 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

C-1 (Rev. 10/07)

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	Claim Number (Insurer's Use Only)
MORRIS	L	DAVID	3-30-60	☒ M ☐ F	
Home Address [redacted]			Age 51 / Height 6Ft	Weight 205	Social Security Number [redacted]
City SPARKS	State NV	Zip 89436		Telephone [redacted]	
Mailing Address	City	State	Zip		Primary Language Spoken

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred

Employer's Name/Company Name	Telephone
WASHOE County	328-2177
Office Mail Address (Number and Street)	
3101 Longley Lane Reno NV. 89520	

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
4-7-11	10 am pm	4-7-11		Tom Matteo

Address or Location of Accident (if applicable)
Lemon Valley RD

What were you doing at the time of the accident? (if applicable)
Filing EXCAVTOR Down IN A Ditch

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
Sliped going Down Bank

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RISK MANAGEMENT DIVISION

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RISK MANAGEMENT DIVISION

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)
Bill Rojos

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
Pulled groin & lower Back R Knee	R L Groin Back. R Knee

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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 4-7-11 Place Concentra Employee's Signature [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)
4/7/11 / 1320	Groin Strain, Knee Strain	

Treatment: Rx Vicodin

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
If modified duty, specify any limitations/restrictions: _____

X-Ray Findings: N/A

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 4/11/11 Print Doctor's Name Robert C. Erwin, DO

I certify that the employer's copy of this form was mailed to the employer on:

Address 255 Glendale Ave Ste #12

City	State	Zip	Provider's Tax I.D. Number	Telephone
Sparks,	NV	89431	TD-01-4828	(775) 358-8181

Doctor's Signature [signature] Degree DC

INSURER'S USE ONLY

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)

PAGE 1

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

RECEIVED OCT 12 2011 W.C.S.O. PAYROLL

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County Sheriffs office			

Office Mail Address	Location . . . If different from mailing address	Telephone
911 Parr Blvd		

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
Reno	NV	89512		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
R.W.	J	Edwards	[redacted]	08-15-73	38	English

Home Address (Number and Street)	Sex	Marital Status
[redacted]	☑ Male ☐ Female	☐ Single ☑ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Carson City	NV	89703	☑ Yes ☐ No	15 yrs

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Deputy Sheriff	Patrol

Telephone	Is the injured employee a corporate officer?	. . . sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☑ No	☐ Yes ☐ No	☐ Yes ☑ No	☑ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
10-11-11	0625 hrs	10-11-11	Sgt. Davis

Address or location of accident (Also provide city, country,state) (if applicable): South SubStation (Douglas)

Accident on employer's premises? (if applicable) ☑ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable): Loading Gear From Pcv into Patrol car.

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

I was loading my Gear From Pcv to Patrol car when I felt Pain in my lower Right Abdomen.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable): Gear Bag

Part of body injured or affected: Lower Right Abdomen

If fatal, give date of death:

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.): Hernia

If validity of claim is doubted, state reason:

Witness RECEIVED OCT 14 2011 WASHOE COUNTY RISK MANAGEMENT DIVISION

Was there more than one person injured in this accident? (if applicable) ☐ Yes ☑ No

Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☑ No

Will you have light duty work available if necessary? ☐ Yes ☐ No

Location of Initial Treatment Concentra 1530 E. 6th St. Reno, NV 89512

Treating physician/chiropractor name: Dr. Stensby

Emergency Room ☐ Yes ☑ No

Hospitalized ☐ Yes ☑ No

IMPORTANT

How many days per week does employee work? 4

From 0600 ☑ am ☐ pm To 1600 ☐ am ☑ pm

Last day wages were earned:

Scheduled days off: S ☑ M ☑ T ☐ W ☐ T ☐ F ☑ S ☑ Rotating ☐

Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
10-14-96			

Was the employee hired to work 40 hours per week? ☑ Yes ☐ No If not, for how many hours a week was the employee hired?

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☐ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more . Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

500 / 16 / 1500 / 1512

Pay period ends on: ☑ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI

Employee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY

On the date of injury or disability, the employee's wage was: $ 29.33 per ☑ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title: [signature] Payroll Clk

Date: 10-12-11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

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OCT 12 2011
W.C.S.O. PAYROLL

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

Name of Employer WASHOE COUNTY SHERIFF'S OFFICE

Name of Employee	Social Security Number	Telephone Number
RON ENCINAS		RECEIVED OCT 14 2011 WASHOE COUNTY RISK MANAGEMENT DIVISION

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
10-11-11	0625	3005 LONGLEY LN RENO NV

What is the nature of the injury or occupational disease?	List any body parts involved:
HERNIA	RT. LOWER ABDOMEN

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)
DEPUTY ENCINAS WAS LIFTING HIS SWAT EQUIPMENT BAG FROM HIS PATROL CAR AND FELT A PAIN IN HIS LOWER RT. ABDOMEN

Names of witnesses:
NONE

Did the employee leave work because of the injury or occupational disease?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
X YES ___ NO	10-11-11 / 1015	___ YES X NO	

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
___ YES X NO		DR. SEENSEY CON CENTRA

Did the accident happen in the normal course of work? (if applicable) X YES ___ NO

Was anyone else involved?	Names of others involved
___ YES X NO	

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: 10-11-11

Signature of Injured or Disabled Employee — Date: 10-11-11

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

C-1 (Rev. 10/05)

188/11

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	Claim Number (Insurer's Use Only)
Ron	J	Encinas	08-08-73	☑ M ☐ F	

Home Address	Age	Height	Weight	Social Security Number
[redacted]	38	5.08	170	[redacted]

City	State	Zip	Telephone
Carson City	NV	89703	(775) 885-6645

Mailing Address	City	State	Zip	Primary Language Spoken
SAA				English

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
	CCMSI	Deputy Sheriff

Employer's Name/Company Name	Telephone
Washoe County Sheriff's office	328-3403

Office Mail Address (Number and Street) 911 Parr Blvd Reno, NV 89512

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
10-11-11	6:15 ☑ am ☐ pm	10-11-11		Sgt. Davis

Address or Location of Accident (if applicable)
South Substation (Longley)

What were you doing at the time of the accident? (If applicable)
Loading my Gear From my car into Patrol car.

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
I picked up a Gear Bag to move it from my car to Patrol car.
Felt Pain in Lower Right Abdomen.

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
	Lwr Right Abdomen

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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 10-11-11 Place Concentra Employee's Signature [signature]

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

Place Name of Facility Concentra Reno

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?
10/11/11 1150	R Inguinal hernia	☒ No ☐ Yes (if yes, please explain)

Treatment: Referred

X-Ray Findings: NA

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
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 Doctor's Name	I certify that the employer's copy of this form was mailed to the employer on:
10/11/11	Harold Stanley	

Address	INSURER'S USE ONLY
1530 E 6th St	

City	State	Zip	Provider's Tax I.D. Number	Telephone
Reno	NV	89512	752014828	3225787

Doctor's Signature	Degree
[signature]	MD

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev. 10/07)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

RECEIVED OCT 10 2011 W.C.S.O. PAYROLL

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County Sheriff's Office	Police/Service		
Office Mail Address	**Location . . . If different from mailing address**		**Telephone**
911 Parr Blvd			328-2977
City / State / Zip	**INSURER**		**THIRD-PART ADMINISTRATOR**
Reno NV 89512	SIF Insured (WC)		

EMPLOYEE

First Name / M.I. / Last Name	Social Security	Birthdate	Age	Primary Language Spoken
David O Dunham	[redacted]	5/19/63	48	English
Home Address (Number and Street)	**Sex** ☐ Male ☐ Female	**Marital Status** ☐ Single ☑ Married ☐ Divorced ☐ Widowed		
[redacted]				
City / State / Zip	**Was the employee paid for the day of injury? (if applicable)** ☑ Yes ☐ No	**How long has this person been employed by you in Nevada?**		
Sparks NV 89436		5 years		
In which state was employee hired?	**Employee's occupation (job title) when hired or disabled**	**Department in which regularly employed:**		
Nevada	Deputy Sheriff	Sheriff		
Telephone	**Is the injured employee a corporate officer? . . . sole proprietor? . . . partner?** ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	**Was employee in your employ when injured or disabled by occupational disease (O/D)?** ☐ Yes ☐ No		
[redacted]				

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
10/6/11	1200 hrs	10/6/11	Sgt Cecil #1341

Address or location of accident (Also provide city, country, state) (if applicable)
Reno / Spectrum

Accident on employer's premises? (if applicable) ☑ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)
Competing in the Northern Nevada SWAT Challenge.

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.
While climbing an obstacle wall, Deputy Dunham felt a pop & pain on left shoulder area.

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)

Witness S. Thomas OCT 12 2011

Part of body injured or affected Left arm & Shoulder

If fatal, give date of death

Witness A. Rivera WASHOE COUNTY RISK MANAGEMENT DIVISION

Was there more than one person injured in this accident? (if applicable) ☐ Yes ☑ No

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.)
Injury to left arm & shoulder.

Witness C. Courtney

Did employee return to next scheduled shift after accident? (if applicable) ☐ Yes ☑ No

Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason
N/A

Location of Initial Treatment
On site by Reno Fire and

Treating physician/chiropractor name
DR. Michael Panicari / Concentra

Emergency Room ☐ Yes ☑ No

Hospitalized ☐ Yes ☑ No

IMPORTANT — **How many days per week does employee work?**

From 0700 ☑ am ☐ pm **To** 1900 ☐ am ☑ pm

Last day wages were earned

Scheduled days off S ☑ M ☐ T ☐ W ☐ T ☐ F ☐ S ☐ Rotating ☐

Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
10/17/2006	10/6/11		

Was the employee hired to work 40 hours per week? ☐ Yes ☐ No **If not, for how many hours a week was the employee hired?**

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☑ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more. Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on: ☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI

Employee is paid: ☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY

On the date of injury or disability the employee's wage was: $ 20 per ☐ Hr ☐ Day ☐ Wk ☐ Mo

500 / 16 / 1504 / 1561

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title Sgt Cecil #1341 **Date** 10/07/11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	**Date**	**Status Clerk**	**Date**

Form C-3 (rev. 11/05) ORIGINAL – EMPLOYER PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYEE

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W.C.S.O. PAYROLL

OCT 12 2011
WASHOE COUNTY
RISK MANAGEMENT DIVISION

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

Name of Employer Washoe County Sheriff's Office.

Name of Employee	Social Security Number	Telephone Number
David O. Dunham	[redacted]	(775) [redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
10/07/11	1200 hrs.	Regional Public Safety Training Center

What is the nature of the injury or occupational disease?	List any body parts involved:
Injury to left Arm & Shoulder	Left Arm & Shoulder.

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)
During the Northern Nevada SWAT Competition, Deputy Dunham was climbing an obstical wall - fell a pop & pain in left Arm & Shoulder area.

Names of witnesses:
Deputies - S. Thomas, A. Biggar, C. Courtney.

Did the employee leave work because of the injury or occupational disease? ✓ YES ___ NO	If yes, when (date and time)? 10/07/11 @ 1245	Has the employee returned to work? ___ YES ✓ NO	If yes, when (date and time)?
Was first aid provided? ✓ YES ___ NO	If yes, by whom? Rensa Personnel	Name and address of treating physician, if applicable or known: Concentra Dr. Michael Panicari	
Did the accident happen in the normal course of work? (if applicable) ✓ YES ___ NO			
Was anyone else involved? ___ YES ✓ NO	Names of others involved: N/A		

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.

Sgt. J. Cossin	10/07/11	David Dunham	10/7/11
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

C-1 (Rev. 10/05)

EMPLOYEE'S CLAIM FOR COMPENSATION/REPORT OF INITIAL ATMENT

FORM C-4

PLEASE TYPE OR PRINT

EMPLOYEE'S CLAIM – PROVIDE ALL INFORMATION REQUESTED

First Name	M.I.	Last Name	Birthdate	Sex	Claim Number (Insurer's Use Only)
DAVID	C	DUNHAM	5/19/83	☒M ☐F	09314972200

Home Address	Age	Height	Weight	Social Security Number
[redacted]	29	6'3"	210	[redacted]

City	State	Zip	Telephone
SPARKS	NV	89436	775 [redacted]

Mailing Address	City	State	Zip	Primary Language Spoken
885 DEL SOL	SPARKS	NV	89436	ENGLISH

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
HOMETOWN HEALTH		DEPUTY SHERIFF

Employer's Name/Company Name	Telephone
WASHOE COUNTY SHERIFF'S OFFICE	775 328 2953

Office Mail Address (Number and Street)			
911 PARR BLVD.	RENO	NV	89486

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
10/7/11	am 0800 pm	10/7/11	10/7/11	SGT. COSTA

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W.C.S.O. PAYROLL

Address or Location of Accident (if applicable)
REGIONAL TRAINING CENTER

What were you doing at the time of the accident? (if applicable)
SWAT COMPETITION.

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
WHILE CLIMBING A WALL DURING THE SWAT CHALLENGE I FELT A POP IN MY RIGHT SHOULDER AREA. A LARGE AMOUNT OF PAIN AND FELT A POP IN MY RIGHT

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)
C. DUNHAM
S. THOMAS
C. COSTA
A. BRAUN

RECEIVED
OCT 12 2011

Nature of Injury or Occupational Disease

Part(s) of Body Injured or Affected
RT ARM.

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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 10/7/11 Place Concentra Employee's Signature C Dunham

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

Place / Name of Facility: Concentra Reno

Date 10/07/11

Diagnosis and Description of Injury or Occupational Disease: Poss. Biceps tear

Hour

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: MRI

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: not done today

If modified duty, specify any limitations/restrictions: no activity

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:

INSURER'S USE ONLY

Address: 1530 E 6th St

City	State	Zip	Provider's Tax I.D. Number	Telephone	Degree
Reno	NV	89512	752014828	3225757	

Doctor's Signature: [signature]

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County	Road Maint		

Office Mail Address	Location . . . If different from mailing address	Telephone
3101 Longley Lane		775-328-2180

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
Reno	NV	89502		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Brandon		Christiansen	[redacted]	7-5-81	29	English

Home Address (Number and Street)	Sex	Marital Status
[redacted]	☒ Male ☐ Female	☐ Single ☒ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Sparks	NV	89436	☒ Yes ☐ No	6 yrs. 6 mos.

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Maintenance Worker II	Public Works - Roads

Telephone	Is the injured employee a corporate officer?	. . . sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
5-25-11	2:50pm	5-26-11	Rick Thomsen

Address or location of accident (Also provide city, country, state) (if applicable)	Accident on employer's premises? (if applicable)
3101 Longley Ln Washoe County, NV	☒ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)
unloading and preparing truck

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.
I bumped my elbow on the truck railing

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable)
Truck used for crack sealing	Tom Raymond	☐ Yes ☒ No

Part of body injured or affected	If fatal, give date of death	Witness
Elbow and arm		

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	Did employee return to next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
Numbness and pain		☒ Yes ☐ No	☒ Yes ☐ No

If validity of claim is doubted, state reason	Location of Initial Treatment	Emergency Room	Hospitalized
	Concentra Medical	☐ Yes ☒ No	☐ Yes ☒ No

IMPORTANT	How many days per week does employee work?	From	To	Last day wages were earned
	4	6:00 ☒ am ☐ pm	4:30 ☐ am ☒ pm	

Scheduled days off	S	M	T	W	T	F	S	Rotating	Are you paying injured or disabled employee's wages during disability?
	☒	☒	☐	☐	☐	☐	☒	☐	☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
3/15/05			

Was the employee hired to work 40 hours per week?	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months?
☒ Yes ☐ No		☐ Yes ☒ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more. Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☐ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	$ per ☐ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title	Date
Carolyn M. Peek Admin Secretary	5-31-11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code

Claims Examiner's Signature	Date	Status Clerk	Date

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

Name of Employer WASHOE COUNTY

Name of Employee	Social Security Number	Telephone Number
BRANDON CHRISTIANSEN	[redacted]	775 [redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
5/25/11	2:50pm	WASHOE COUNTY ROADS COMPLEX

What is the nature of the injury or occupational disease?	List any body parts involved:
PAIN, NUMBNESS, AND DISCOMFORT	ELBOW. Left

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)
I WAS UNLOADING TRUCK WHEN I BUMPED MY ELBOW ON RAILING. MY ARM WENT NUMB. IT TINGLED AND HURT. I NOTIFIED MY SUPERVISOR ON 5/26/11

Names of witnesses:

Did the employee leave work because of the injury or occupational disease? ___ YES X NO	If yes, when (date and time)?	Has the employee returned to work? N/A YES ___ NO	If yes, when (date and time)?
Was first aid provided? ___ YES X 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) X YES ___ NO			
Was anyone else involved? ___ YES X 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.

[signature] 5-26-11
Supervisor's Signature Date

[signature] 5-26-11
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

C-1 (Rev. 10/05)

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	Claim Number (Insurer's Use Only)
Brandon	D	Christensen	07/05/1981	☑M ☐F	

Home Address	Age	Height	Weight	Social Security Number
[redacted]	29	205		

City	State	Zip	Telephone
Sparks	NV	89436	775- [redacted]

Mailing Address	City	State	Zip	Primary Language Spoken
SAME AS ABOVE				English

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
CCMSI		MWIT

Employer's Name/Company Name	Telephone
Washoe County Roads	
Office Mail Address (Number and Street)	

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
5/25/11	2 am 50 pm	5/26/11		Rich Thomsen

Address or Location of Accident (If applicable)
County Roads Yard

What were you doing at the time of the accident? (If applicable)
I was unloading tools

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
I banged my left elbow on raining

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)
The next day	Tom Raymond

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
	Elbow, Arm left

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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 6-1-11 Place Concentra Employee's Signature [signature]

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

Place Name of Facility

Date	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)
6-1-11	Elbow Contusion	
Hour 0810		
Treatment: Ice, Tylenol 3/10 Ice elbow sleeve 5/wks 6/17 work		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: No		If modified duty, specify any limitations/restrictions: Ice elbow sleeve
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:
6-1-11	[redacted]	

Address				INSURER'S USE ONLY
255 Glendale Ave. Ste 7-12				RECEIVED
City	State	Zip	Provider's Tax I.D. Number	Telephone
Sparks	NV	89431	75-[redacted]	(775) 355-8181
Doctor's Signature			Degree	JUN 1 2011
[signature]			MD	CCMSI - RENO

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYER Form C-4 (rev.10/07)

PAGE 1

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF THE RECEIPT OF THE C-4 FORM

PLEASE TYPE OR PRINT

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County Juvenile Services	Juvenile Detention		

Office Mail Address	Location . . . If different from mailing address	Telephone
PO Box 11130	650 Ferrari-McLeod	328-2218

City	State	Zip	INSURER	THIRD-PART ADMINISTRATOR
Reno	NV	89520		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Mia		Boschetti	[redacted]	4-15-86	25	English

Home Address (Number and Street)	Sex	Marital Status
[redacted]	☐ Male ☒ Female	☒ Single ☐ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (if applicable)	How long has this person been employed by you in Nevada?
Reno	NV	89503	☒ Yes ☐ No	1 year

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
NV	Youth Advisor	Juvenile Services

Telephone	Is the injured employee a corporate officer?	. . . sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
[redacted]	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
10-15-11	3:30 pm	10-5-11	Alan Jay

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OCT 11 2011
WASHOE COUNTY
MANAGEMENT DIVISION

Address or location of accident (Also provide city, country, state) (if applicable)	Accident on employer's premises? (if applicable)
650 Ferrari-McLeod	☒ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)
Defensive Tactics training

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.
during training on incorrect technique was used by Mia's partner resulting in injury

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)	Witness	Was there more than one person injured in this accident? (if applicable)
gym mat	Alan Jay	☐ Yes ☒ No

Part of body injured or affected	If fatal, give date of death	Witness
head neck back knee chest		Holly Tapia

Nature of injury or Occupational Disease (scratch, cut, bruise, strain, etc.)	Witness	Did employee return to next scheduled shift after accident? (if applicable)	Will you have light duty work available if necessary?
bruising, straining Lumbar, Neck, Thoracic Sprain		☐ Yes ☒ No	☒ Yes ☐ No

If validity of claim is doubted, state reason	Location of Initial Treatment
	Concentra

Treating physician/chiropractor name	Emergency Room	Hospitalized
	☐ Yes ☒ No	☐ Yes ☒ No

IMPORTANT: How many days per week does employee work?	From	To	Last day wages were earned
5	9:00 ☐ am ☒ pm	10:00 ☐ am ☒ pm	10-6-2011

Scheduled days off	S	M	T	W	T	F	S	Rotating
	☐	☒	☒	☐	☐	☐	☐	☐

Are you paying injured or disabled employee's wages during disability? ☒ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
8-2-10	10-5-11		

Was the employee hired to work 40 hours per week?	If not, for how many hours a week was the employee hired?	Did the employee receive unemployment compensation any time during the last 12 months?
☒ Yes ☐ No		☐ Yes ☒ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more. Attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 1 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☒ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☐ BI-WKLY ☐ SEMI-MONTHLY	$ 20.52 per ☒ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title	Date
Sheree Carlson Admin Tech Sr.	10-6-11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

"NOTICE OF INJURY OR OCCUPATIONAL DISEASE"

(Incident Report)

Pursuant to NRS 616C.015

RECEIVED
OCT 11 2011
WASHOE COUNTY
RISK MANAGEMENT DIVISION

Name of Employer Washoe County Juvenile Services

Name of Employee	Social Security Number	Telephone Number
Mia Bosetti	[redacted]	[redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)
10/5/11	1530	Jan Evans Gymnasium

What is the nature of the injury or occupational disease?	List any body parts involved:
injury	neck, back, back of head, Chest

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)
rear choke escape - Mia was accidentally placed on the grand-hard - she started to become dizzy + nauseas according to her own statement

Names of witnesses:
Alan Jay, Holly Tapia

Did the employee leave work because of the injury or occupational disease?	If yes, when (date and time)?	Has the employee returned to work?	If yes, when (date and time)?
✓ YES ___ NO	10/5/11 - 1500	___ YES ✓ NO	

Was first aid provided?	If yes, by whom?	Name and address of treating physician, if applicable or known
✓ YES ___ NO	J. Lang	

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.

AJay — 10/5/11
Supervisor's Signature — Date

not available to sign
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

C-1 (Rev. 10/05)

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	Claim Number (Insurer's Use Only)
Mia	C	Bassett	04/15/1980	☐M ☒F	

Home Address	Age	Height	Weight	Social Security Number
[redacted]	25	5'9"	170	[redacted]

City	State	Zip	Telephone
Reno	NV	89503	775-[redacted]

Mailing Address	City	State	Zip	Primary Language Spoken
N/A				English

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
CDS		Youth Advisor I

Employer's Name/Company Name	Telephone
Washoe County Dept Juvenile Services	775 385-7810

Office Mail Address (Number and Street): 650 Ferrari Mcleod Reno NV 89512

Date of Injury (If applicable)	Hours Injury (If applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
10/5/11	am 1530 pm	10/5/11		Ron Herzig

Address or Location of Accident (If applicable): 650 Ferrari Mcleod Reno NV 89512

What were you doing at the time of the accident? (If applicable): Defensive Tactics Training

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)

I was practicing a chokehold escape with a fellow employee, and hit the ground hard on my back multiple times. The last time I hit my head + never regained breath.

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)
	Alan Jay Holly Tapia

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
	Head, Neck, Chest, Back

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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 10/5/11 Place Concentra Employee's Signature [signature]

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

Place	Name of Facility
Office	Concentra

Date	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?
10/5/11	Cervical strain/ lumbar strain	☒ No ☐ Yes (If yes, please explain)
Hour 1700		

Treatment: med, work limit

X-Ray Findings: N/A

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

If modified duty, specify any limitations/restrictions: ~ Lift, [illegible]

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:
10/5/11	DING PETERS	

Address		INSURER'S USE ONLY
255 Glendale Ave #12		

City State Zip	Provider's Tax I.D. Number	Telephone
Sparks NV 8943[illegible]	752014028	7753568191

Doctor's Signature	Degree
[signature]	MD

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)

TO AVOID PENALTY, THIS REPORT MUST BE COMPLETED AND MAILED TO THE INSURER WITHIN 6 WORKING DAYS OF RECEIPT OF THE C-4 FORM

Please Type or Print

EMPLOYER'S REPORT OF INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE

EMPLOYER

Employer's Name	Nature of Business (mfg., etc.)	FEIN	OSHA Log #
Washoe County	government		144/11

Office Mail Address	Location . . . If different from mailing address	Telephone
PO Box 11130	1001 E 9th St, Reno	775-328-2552

City	State	Zip	INSURER	THIRD-PARTY ADMINISTRATOR
Reno	NV	89520		

EMPLOYEE

First Name	M.I.	Last Name	Social Security	Birthdate	Age	Primary Language Spoken
Laura	R	Ash	[redacted]	6/1/59	52	ENGLISH

Home Address (Number and Street): [redacted]

Sex ☐ Male ☒ Female — Marital Status ☐ Single ☒ Married ☐ Divorced ☐ Widowed

City	State	Zip	Was the employee paid for the day of injury? (If applicable)	How long has this person been employed by you in Nevada?
Sparks	NV	89436	☒ Yes ☐ No	since 10/4/2004

In which state was employee hired?	Employee's occupation (job title) when hired or disabled	Department in which regularly employed:
Nevada	Account Clerk	Comptroller's Office

Telephone	Is the injured employee a corporate officer?	. sole proprietor?	. . . partner?	Was employee in your employ when injured or disabled by occupational disease (O/D)?
775-[redacted]	☐ Yes ☒ No	☐ Yes ☒ No	☐ Yes ☒ No	☒ Yes ☐ No

ACCIDENT OR DISEASE

Date of Injury (if applicable)	Time of injury (Hours; Minute AM/PM) (if applicable)	Date employer notified of injury or O/D	Supervisor to whom injury or O/D reported
8/2/11	9 AM - reported	8/2/11	Sheri Mendez

Address or location of accident (Also provide city, county, state) (if applicable)

Accident on employer's premises? (if applicable) ☐ Yes ☐ No

What was this employee doing when the accident occurred (loading truck, walking down stairs, etc.)? (if applicable)

How did this injury or occupational disease occur? Include time employee began work. Be specific and answer in detail. Use additional sheet if necessary.

Over a long period of time, pain & numbness in hands got progressively worse

INJURY OR DISEASE

Specify machine, tool, substance, or object most closely connected with the accident (if applicable)

Witness: Jim Cashron

Witness:

Witness:

Was there more than one person injured in this accident? (if applicable) ☐ Yes ☐ No

Part of body injured or affected: right & left wrists, Primarily right

If fatal, give date of death:

Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)

lateral Epicondylitis

other tenosynovitis of hand, wrist

Did employee return to next scheduled shift after accident? (if applicable) ☒ Yes ☐ No

Will you have light duty work available if necessary? ☐ Yes ☐ No

If validity of claim is doubted, state reason

Location of Initial Treatment: Concentra

Treating physician/chiropractor name: Van Cleave

Emergency Room ☐ Yes ☒ No

Hospitalized ☐ Yes ☒ No

IMPORTANT

How many days per week does employee work? 5

From 7 ☐ am ☐ pm To 5 ☐ am ☐ pm

Last day wages were earned: 8/2/11

Scheduled days off: S ☒ M ☐ T ☐ W ☐ T ☐ F ☐ S ☒ Rotating ☐

Are you paying injured or disabled employee's wages during disability? ☐ Yes ☐ No

IMPORTANT LOST TIME INFO

Date employee was hired	Last day of work after injury or disability	Date of return to work	Number of work days lost
10/4/2004	8/2/11	8/2/11	0

Was the employee hired to work 40 hours per week? ☒ Yes ☐ No — If not, for how many hours a week was the employee hired?

Did the employee receive unemployment compensation any time during the last 12 months? ☐ Yes ☒ No ☐ Do not know

For the purpose of calculation of the average monthly wage, indicate the employee's gross earnings by pay period for 12 weeks prior to the date of injury or disability. If the injured employee is expected to be off work 5 days or more, attach wage verification form (D-8). Gross earnings will include overtime, bonuses, and other remuneration, but will not include reimbursement for expenses. If the employee was employed by you for less than 12 weeks, provide gross earnings from the date of hire to the date of injury or disability.

Pay period ends on:	Employee is paid:	On the date of injury or disability the employee's wage was:
☒ SUN ☐ TUE ☐ THUR ☐ SAT ☐ MON ☐ WED ☐ FRI	☐ WEEKLY ☐ MONTHLY ☐ OTHER ☒ BI-WKLY ☐ SEMI-MONTHLY	$11.44 per ☒ Hr ☐ Day ☐ Wk ☐ Mo

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

★ I affirm that the information provided above regarding the accident and injury or occupational disease is correct to the best of my knowledge. I further affirm the wage information provided is true and correct as taken from the payroll records of the employee in question. I also understand that providing false information is a violation of Nevada law.

Employer's Signature and Title: [redacted]

Date: 8/4/11

Insurer Use Only

Claim is: ☐ Accepted ☐ Denied ☐ Deferred ☐ 3rd Party	Deemed Wage	Account No.	Class Code
Claims Examiner's Signature	Date	Status Clerk	Date

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

Name of Employer Washoe County

Name of Employee	Social Security Number	Telephone Number
LAURA R. ASH	[redacted]	[redacted]

Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred
N/A	N/A	N/A

What is the nature of the injury or occupational disease?	List any body parts involved:
LATERAL EPICONDYLITIS	Right & Left WRISTS

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)

8/2/11 RISK MANAGER NOTICED LAURA RUBBING HER WRIST.

PAIN & NUMBNESS IN HANDS

Name of witnesses: Jim Caughron

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)?	8/2/11
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 HAS 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 8-2-11

Signature of Injured or Disabled Employee — Date 8/2/11

RECEIVED
AUG 05 11
CCMSI-RENO

TO FILE ACLAIM FOR COMPENSATION, SEE REVERSE SIDE, SECTION ENTITLED, CLAIM FOR COMPENSATION (FORM C-4).

Employee should sign, date and retain a copy.

ORGINAL TO EMPLOYER, COPY TO EMPLOYEE

C-1

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	Claim Number (Insurer's Use Only)
Laura	R	Ash	6/1/1959	☐ M ☒ F	

Home Address	Age	Height	Weight	Social Security Number
[redacted]	52	5'2"	135	[redacted]

City	State	Zip	Telephone
Sparks	NV	89436	775-[redacted]

Mailing Address	City	State	Zip	Primary Language Spoken
Same as above				English

INSURER	THIRD-PARTY ADMINISTRATOR	Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred
	CCMSI	Account Clerk

Employer's Name/Company Name	Telephone
Washoe County Comptroller	775-328-2552

Office Mail Address (Number and Street): 1001 E 9th St, Reno NV 89512

Date of Injury (if applicable)	Hours Injury (if applicable)	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported
8/2/11	9 am pm	8/2/11	8/2/11	Sheri Mendez

Address or Location of Accident (if applicable): 1001 E 9th St, Reno, NV 89512

What were you doing at the time of the accident? (if applicable): working at my desk

How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)
Our risk manager stopped to talk + noticed me rubbing my right wrist + asked what was wrong to which I replied carpal tunnel, I believe, and here I am.

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): Jim Caughron

Nature of Injury or Occupational Disease	Part(s) of Body Injured or Affected
I think it's carpal tunnel	right + left wrists

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 OTHER PERSON, ANY HOSPITAL, INCLUDING VETERANS 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 8/2/11 Place Concentra Employee's Signature [signature]

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

Place: Concentra Reno — Name of Facility

Date: 8-2-11 — Hour:

Diagnosis and Description of Injury or Occupational Disease: Lt wrist tenosynovitis + (R) lat epicondylitis

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: brace, RT

Have you advised the patient to remain off work five days or more? ☐ Yes Indicate dates: from _____ to _____

X-Ray Findings: see report

☒ No If no, is the injured employee capable of: ☐ full duty ☒ modified duty

If modified duty, specify any limitations/restrictions: wear brace

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:
8-2-11	M Ponican MD	

Address		INSURER'S USE ONLY
1530 E 6th St		

City	State	Zip	Provider's Tax I.D. Number	Telephone
Reno	NV	89512	[redacted]	322-5757

Doctor's Signature [signature] Degree

ORIGINAL – TREATING PHYSICIAN OR CHIROPRACTOR PAGE 2 – INSURER/TPA PAGE 3 – EMPLOYER PAGE 4 – EMPLOYEE Form C-4 (rev.10/07)