

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 #			
	Office Mail Address			Location . . . If different from mailing address			Telephone			
	City		State	Zip	INSURER		THIRD-PARTY ADMINISTRATOR			
EMPLOYEE	First Name	M.I.	Last Name		Social Security	Birthdate	Age	Primary Language Spoken		
	Home Address (Number and Street)				Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
	City		State	Zip	Was the employee paid for the day of injury? (If applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No		How long has this person been employed by you in Nevada?			
	In which state was employee hired?		Employee's occupation (job title) when hired or disabled			Department in which regularly employed:				
	Telephone	Is the injured employee a corporate officer? . . . sole proprietor? . . . partner? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No				Was employee in your employ when injured or disabled by occupational disease (O/D)? <input type="checkbox"/> Yes <input type="checkbox"/> 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				
	Address or location of accident (Also provide city, county, state) (if applicable)					Accident on employer's premises? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> 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.									
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) <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Part of body injured or affected		If fatal, give date of death		Witness					
	Nature of Injury or Occupational Disease (scratch, cut, bruise, strain, etc.)				Witness					
	If validity of claim is doubted, state reason				Did employee return to next scheduled shift after accident? (if applicable) <input type="checkbox"/> Yes <input type="checkbox"/> No		Will you have light duty work available if necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Treating physician/chiropractor name				Location of Initial Treatment		Emergency Room <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No		
	IMPORTANT	How many days per week does employee work?		From	<input type="checkbox"/> am <input type="checkbox"/> pm	To	<input type="checkbox"/> am <input type="checkbox"/> pm	Last day wages were earned		
Scheduled days off	S	M	T	W	T	F	S	Rotating <input type="checkbox"/>	Are you paying injured or disabled employee's wages during disability? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> SUN <input type="checkbox"/> TUE <input type="checkbox"/> THUR <input type="checkbox"/> SAT ends on: <input type="checkbox"/> MON <input type="checkbox"/> WED <input type="checkbox"/> FRI			Employee is paid: <input type="checkbox"/> WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER <input type="checkbox"/> BI-WKLY <input type="checkbox"/> SEMI-MONTHLY			On the date of injury or disability the employee's wage was: \$ _____ per <input type="checkbox"/> Hr <input type="checkbox"/> Day <input type="checkbox"/> Wk <input type="checkbox"/> Mo			
For assistance with Workers' Compensation Issues you may contact the State of Nevada Office of the Consumer Health Assistance Toll Free: 1-888-333-1597 Web site: http://dhhs.nv.gov/Programs/CHA E-mail: cha@govcha.nv.gov										
Insurer Use Only	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			
	Claim is: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Deferred <input type="checkbox"/> 3 rd 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 _____

Name of Employee		Social Security Number		Telephone Number	
Date of Accident (if applicable)	Time of Accident (if applicable)	Place where accident occurred (if applicable)			
What is the nature of the injury or occupational disease?			List any body parts involved:		
Briefly describe accident or circumstances of occupational disease: (Note: if you are claiming an occupational disease, indicate the date on which employee first became aware of connection between condition and employment)					
Names of witnesses:					
Did the employee leave work because of the injury or occupational disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when (date and time)?	Has the employee returned to work?	<input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when (date and time)?
Was first aid provided?	<input type="checkbox"/> YES <input type="checkbox"/> 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)	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Was anyone else involved?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Names of others involved			

MY EMPLOYER/INSURER MAY HAVE MADE ARRANGEMENTS TO DIRECT ME TO A HEALTH CARE PROVIDER FOR MEDICAL TREATMENT OF MY INDUSTRIAL INJURY OR OCCUPATIONAL DISEASE. I HAVE BEEN NOTIFIED OF THESE ARRANGEMENTS.

Supervisor's Signature

Date

Signature of Injured or Disabled Employee

Date

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

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

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

A T T E N T I O N

Caution: The information below is general in nature and is not intended to be legal advice. If you have any questions regarding your status as an employer or employee or your rights and qualification for specific benefits under an industrial injury or occupational disease claim, you should consult with an attorney experienced in industrial insurance.

Brief Description of Whether the Employer is Required to Obtain Industrial Insurance and Whether a Person is a Covered Employee

Every employer ... shall provide and secure compensation ... for any personal injuries by accident sustained by an employee arising out of and in the course of the employment. See NRS 616B.612(1).

An **employer** is defined as, "Every person, firm, voluntary association and private corporation, including any public service corporation, which has in service any person under a contract of hire." See NRS 616A.230(2). "A person is not an employer if: (a)The person enters into a contract with another person or business which is an independent enterprise; and (b) The person is not in the same trade, business, profession or occupation as the independent enterprise." See NRS 616B.603(1).

An **employee** is broadly defined as, "... every person in the service of an employer under any appointment or contract of hire or apprenticeship, express or implied, oral or written, whether lawfully or unlawfully employed" (See NRS 616A.105), but excludes casual employees not in the same trade, business, profession or occupation; musicians not lasting more than 2 consecutive days; household servants, farming and ranching employees; voluntary ski patrol; sports officials paid a nominal fee; clergy, rabbi or lay readers; real estate brokers or sales persons; and commissioned sales persons (See NRS 616A.110).

An **independent contractor** is a person who is hired and paid solely to produce a result. It is defined as, "... any person who renders service for a specified recompense for a specified result, under the control of the person's principal as to the result of the person's work only and not as to the means by which such result is accomplished." See NRS 616A.255.

Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease

Notice of Injury or Occupational Disease (Incident Report Form C-1) If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation, your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a lump-sum PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer**, by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer hearing. NAIW is an independent state agency and is not affiliated with any insurer. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830.

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 3360 W. Sahara Ave., Suite 250, Las Vegas, NV 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 3320 West Sahara Avenue, Suite 100, Las Vegas, Nevada 89102, **Toll Free** 1- 888-333-1597, Web site: <http://dhhs.nv.gov/Programs/CHA>, **E-mail** cha@govcha.nv.gov

The information in this publication is derived from Chapters 616A through 616D, inclusive, and 617 of the Nevada Revised Statutes and is provided for informational purposes only. If you have any questions, regarding your injury or workers' compensation claim, please call the following:

Insurer/Administrator: _____ Contact Person: _____

Address: _____ Telephone Number: _____
City State Zip

MCO/Health Care Provider: _____ Contact Person: _____

Address: _____ Telephone Number: _____
City State Zip

BRIEF DESCRIPTION OF RIGHTS AND BENEFITS
(Pursuant to NRS 616C.050)

Notice of Injury or Occupational Disease (Incident Report Form C-1): If an injury or occupational disease (OD) arises out of and in the course of employment, you must provide written notice to your employer as soon as practicable, but no later than 7 days after the accident or OD. Your employer shall maintain a sufficient supply of the required forms.

Claim for Compensation (Form C-4): If medical treatment is sought, the form C-4 is available at the place of initial treatment. A completed "Claim for Compensation" (Form C-4) must be filed within 90 days after an accident or OD. The treating physician or chiropractor must, within 3 working days after treatment, complete and mail to the employer, the employer's insurer and third-party administrator, the Claim for Compensation.

Medical Treatment: If you require medical treatment for your on-the-job injury or OD, you may be required to select a physician or chiropractor from a list provided by your workers' compensation insurer, if it has contracted with an Organization for Managed Care (MCO) or Preferred Provider Organization (PPO) or providers of health care. If your employer has not entered into a contract with an MCO or PPO, you may select a physician or chiropractor from the Panel of Physicians and Chiropractors. Any **medical costs** related to your industrial injury or OD will be paid by your insurer.

Temporary Total Disability (TTD): If your doctor has certified that you are unable to work for a period of at least 5 consecutive days, or 5 cumulative days in a 20-day period, or places restrictions on you that your employer does not accommodate, you may be entitled to TTD compensation.

Temporary Partial Disability (TPD): If the wage you receive upon reemployment is less than the compensation for TTD to which you are entitled, the insurer may be required to pay you TPD compensation to make up the difference. TPD can only be paid for a maximum of 24 months.

Permanent Partial Disability (PPD): When your medical condition is stable and there is an indication of a PPD as a result of your injury or OD, within 30 days, your insurer must arrange for an evaluation by a rating physician or chiropractor to determine the degree of your PPD. The amount of your PPD award depends on the date of injury, the results of the PPD evaluation, your age and wage.

Permanent Total Disability (PTD): If you are medically certified by a treating physician or chiropractor as permanently and totally disabled and have been granted a PTD status by your insurer, you are entitled to receive monthly benefits not to exceed 66 2/3% of your average monthly wage. The amount of your PTD payments is subject to reduction if you previously received a lump-sum PPD award.

Vocational Rehabilitation Services: You may be eligible for vocational rehabilitation services if you are unable to return to the job due to a permanent physical impairment or permanent restrictions as a result of your injury or occupational disease.

Transportation and Per Diem Reimbursement: You may be eligible for travel expenses and per diem associated with medical treatment.

Reopening: You may be able to reopen your claim if your condition worsens after claim closure.

Appeal Process: If you disagree with a written determination issued by the insurer or the insurer does not respond to your request, you may appeal to the **Department of Administration, Hearing Officer**, by following the instructions contained in your determination letter. You must appeal the determination within 70 days from the date of the determination letter at 1050 E. William Street, Suite 400, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 210, Las Vegas, Nevada 89102. If you disagree with the Hearing Officer decision, you may appeal to the **Department of Administration, Appeals Officer**. You must file your appeal within 30 days from the date of the Hearing Officer decision letter at 1050 E. William Street, Suite 450, Carson City, Nevada 89701, or 2200 S. Rancho Drive, Suite 220, Las Vegas, Nevada 89102. If you disagree with a decision of an Appeals Officer, you may file a **petition for judicial review with the District Court**. You must do so within 30 days of the Appeal Officer's decision. You may be represented by an attorney at your own expense or you may contact the NAIW for possible representation.

Nevada Attorney for Injured Workers (NAIW): If you disagree with a hearing officer decision, you may request that NAIW represent you without charge at an Appeals Officer Hearing. For information regarding denial of benefits, you may contact the NAIW at: 1000 E. William Street, Suite 208, Carson City, NV 89701, (775) 684-7555, or 2200 S. Rancho Drive, Suite 230, Las Vegas, NV 89102, (702) 486-2830

To File a Complaint with the Division: If you wish to file a complaint with the Administrator of the Division of Industrial Relations (DIR), please contact the Workers' Compensation Section, 400 West King Street, Suite 400, Carson City, Nevada 89703, telephone (775) 684-7270, or 3360 West Sahara Avenue, Suite 250, Las Vegas, Nevada 89102, telephone (702) 486-9080.

For Assistance with Workers' Compensation Issues: You may contact the State of Nevada Office for Consumer Health Assistance, 3320 West Sahara Avenue, Suite 100, Las Vegas, Nevada 89102, Toll Free 1-888-333-1597, Web site: <http://dhhs.nv.gov/Programs/CHA> E-mail: cha@govcha.nv.gov

NOTICE TO EMPLOYEES

Pursuant to: **NRS 616B.227 Election by employee to report his tips; effect; regulation.**

1. For the purpose of workers' compensation, an employee may elect to report the amount he receives as tips for the purpose of the calculation of compensation by submitting to his employer an Employee's Declaration of Election of Report Tips (form D-23). The employee must make his election separately for each pay period before the end of the next pay period. The declaration may not be amended.
2. Upon receipt of such notice the employer shall:
 - (a) Make a copy of each report which the employee has filed with the employer to report the amount of his tips to the United States Internal Revenue Service or Employee's Declaration of Election to Report Tips;
 - (b) Submit the copy to its workers' compensation insurer upon request, or if the employer is self-insured or an association of self-insured public or private employers, retain the copy for his records; and
 - (c) If he is not self-insured, pay the insurer the premiums for the reported tips at the same rate as he pays on regular wages.
3. An employee who elects to report his tips is not eligible to receive increased compensation based on those tips until 3 months after his employer receives the Employee's Declaration of Election to Report Tips. For the purpose of workers' compensation, tips may be reported pursuant to 26 U.S.C. §6053(a) or on form D-23. The form for reporting tips D-23 can be obtained from your personnel office.

If the forms are not available, contact your employer or the Internal Revenue Service.

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 <input type="checkbox"/> M <input type="checkbox"/> F	Claim Number (Insurer's Use Only)			
Home Address			Age	Height	Weight	Social Security Number		
City		State	Zip		Telephone			
Mailing Address		City	State	Zip	Primary Language Spoken			
INSURER			THIRD-PARTY ADMINISTRATOR		Employee's Occupation (Job Title) When Injury or Occupational Disease Occurred			
Employer's Name/Company Name					Telephone			
Office Mail Address (Number and Street)								
Date of Injury (if applicable)	Hours Injury (if applicable) am pm	Date Employer Notified	Last Day of Work After Injury or Occupational Disease	Supervisor to Whom Injury Reported				
Address or Location of Accident (if applicable)								
What were you doing at the time of the accident? (if applicable)								
How did this injury or occupational disease occur? (Be specific and answer in detail. Use additional sheet if necessary)								
If you believe that you have an occupational disease, when did you first have knowledge of the disability and its relationship to your employment?					Witnesses to the Accident (if applicable)			
Nature of Injury or Occupational Disease			Part(s) of Body Injured or Affected					
I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE PROVIDED THIS INFORMATION IN ORDER TO OBTAIN THE BENEFITS OF NEVADA'S INDUSTRIAL INSURANCE AND OCCUPATIONAL DISEASES ACTS (NRS 616A TO 616D, INCLUSIVE OR CHAPTER 617 OF NRS). I HEREBY AUTHORIZE ANY PHYSICIAN, CHIROPRACTOR, SURGEON, PRACTITIONER, OR 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	Employee's 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please explain)					
Hour								
Treatment:		Have you advised the patient to remain off work five days or more? <input type="checkbox"/> Yes Indicate dates: from _____ to _____ <input type="checkbox"/> No If no, is the injured employee capable of: <input type="checkbox"/> full duty <input type="checkbox"/> modified duty If modified duty, specify any limitations/restrictions: _____						
X-Ray Findings:								
From information given by the employee, together with medical evidence, can you directly connect this injury or occupational disease as job incurred? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Is additional medical care by a physician indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Do you know of any previous injury or disease contributing to this condition or occupational disease? <input type="checkbox"/> Yes <input type="checkbox"/> No (Explain if yes)								
Date	Print Doctor's Name		I certify that the employer's copy of this form was mailed to the employer on:					
Address				INSURER'S USE ONLY				
City	State	Zip	Provider's Tax I.D. Number				Telephone	
Doctor's Signature			Degree					