STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
Division of Industrial Relations

1886 East College Pkwy,
Suite 100
Carson City, Nevada 89706

2300 West Sahara Avenue,
Suite 300
Las Vegas, Nevada 89102

FATALITY REPORT

(Pursuant to NAC 616B.018)

(Note: The insurer must notify the Administrator within 48 hours after receiving notice of a fatality)

To: ADMINISTRATOR, D.I.R.
From:
Address:
Date:

Deceased: _____ D.O.B._____ SSN: _____
Address: _____
City: _____ County: _____ State: _____

Date of Accident or onset of Occupational Disease: _____ Time: _____ ☐AM☐PM
Date of Death: _____
Marital Status: _____ Name of Spouse: _____ No of Dependents: _____
Name of Dependent: _____ D.O.B. _____ Relationship: _____
Name of Dependent: _____ D.O.B. _____ Relationship: _____
Name of Dependent: _____ D.O.B. _____ Relationship: _____

Employer: _____ Type of Business: _____
Address: _____
Deceased Employee's Occupation: _____
Exact Location of Accident (if applicable):

Describe Accident or Occupational Disease:

Reported By: _____
Title: _____