



## Employer Account Information

Please return this form by fax/email to:  
775 887-5040 – Joanna@NvOHC.com

Employer: _____	Phone Number: _____
Street Address: _____	Fax Number: _____
_____	Primary Contact: _____
_____	Email Address: _____

Workers Comp. Ins. Carrier (Name & Address): _____ _____	<b>Policy Number:</b> _____
_____	Phone Number: _____
_____	Fax Number: _____
_____	Primary Contact: _____
Email Address: _____	Exp. Date: _____

Third Party Administrator (Name & Address): _____ _____	Phone Number: _____
_____	Fax Number: _____
_____	Primary Contact: _____
_____	Email Address: _____

Additional Contact information and Reporting Requirements

Please include a current Workers Compensation Insurance Certificate with this form.