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EMPLOYER'S FIRST REPORT OF INJURY (E-1) COMPLETION HELP SHEET

Please provide as much information as possible. However, the following is the bare minimum needed to establish a new Workers' Compensation Claim. Once completed please mail of fax the form to **505-345-0656. Please be aware, the current Workers' Compensation Law allows an employer only 48 calendar hours, from when they were aware of an injury, to file a claim with their carrier.**

GENERAL: This is the section asking for information about you. What we need here is the name and address of your Company (specifically the name and address your policy is under). If you are using an E-1 from your policy packet, this has likely been pre-filled for you.

CARRIER: if you know it, we need your policy number. If you do not know it, give us a call **1-800-788-8851**. Again, if you are using an E-1 from your policy packet, this has likely been pre-filled for you.

EMPLOYEE: In order to set up the claim we **must** have the following information:
Name: Worker's legal name
Date of Birth: Worker's Date of Birth
Social Security Number: If not known due to immigration status please contact us.
Date Hired: Date of Worker's most recent hire
Gender: Male vs. Female
Occupation: What is the injured worker's job? I.E., laborer, salesman, nurse, etc.

WAGE: This information is needed if the injured worker either is missing work or may miss work.

OCCURANCE: This is the section for you to tell us what happened; what caused your employee to become injured. For the claim to be set up we need at least the following information:
Date of Injury: When was your employee injured?
Date Employer Notified: When were you told, or when you knew, there had been an injury?
Date Disability Began: If your employee is missing time from work, when did this begin? Sometimes this is the same as the date of injury, other times it is later.
Contact Name/Phone Number: Who would you like us to speak with, in your organization, about this claim?
Type of Injury: I.E., laceration, bruise, contusion (scrape), strain etc.
Part of Body Effected: I.E., hand, back, knee, scalp, head etc.
How Injury or Illness Occurred: use this space to tell us what happened. Be as specific as possible, use additional paper if needed.
Date Returned to Work: If your employee has, or has not, returned to work please let us know here.

TREATMENT:

Physician or Hospital: Where is your employee receiving medical care?

Initial Treatment Boxes: What level of care is/was provided?

OTHER:

Witnesses: Was there a witness to the event? If so, please tell us who that person is here.

Date Prepared: Date you completed this form.

Preparer's Name & Title: Please give us your name and phone number here.