**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**

|  |  |
| --- | --- |
| EMPLOYERS’ FIRST REPORT OF INJURY OR ILLNESS | OFFICIAL USE ONLY |
| 1820 RANDOLPH RD SE, PO BOX 27198  ALBUQUERQUE, NM 87125-7198 |

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| G  E  N  E  R  A  L |  | EMPLOYER ( NAME & ADDRESS INCL ZIP ) | | | | | | | | | | | | | | | | | CARRIER / ADMINISTRATOR CLAIM NUMBER | | | | | | | | | | | | | | | | | | | | | | REPORT PURPOSE CODE | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | JURISDICTION | | | | | | | | | | | | | | JURISDICTION CLAIM NUMBER | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | INSURED REPORT NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | EMPLOYER’S LOCATION ADDRESS (IF DIFFERENT) | | | | | | | | | | | | | | | | | | | LOCATION # | | | | | | | | | | | | | |
| SIC CODE | | | | | EMPLOYER FEIN | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | PHONE # | | | | | | | | | | | | | |
| C  A  R  R  I  E  R | C  L  A  I  M  A  D  M  I  N | CARRIER ( NAME, ADDRESS & PHONE NO ) | | | | | | | | | | | | | | | | | POLICY PERIOD | | | | | | | | | | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | TO | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | CHECK IF APPROPRIATE | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
|  | | SELF INSURANCE | | | | | | | |
| CARRIER FEIN | | | | | | | | | | | POLICY / SELF-INSURED NUMBER | | | | | | | | | | | | | | | | | | | | ADMINISTRATOR FEIN | | | | | | | | | | | | | | | | | | |
| AGENT NAME & CODE NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| E  M  P  L  O  Y  E  E |  | NAME ( LAST, FIRST, MIDDLE ) | | | | | | | | | | | | | | | | | DATE OF BIRTH | | | | | | | SOCIAL SECURITY NUMBER | | | | | | | | DATE HIRED | | | | | | | | | | | STATE OF HIRE | | | | | |
| ADDRESS ( INCL ZIP ) | | | | | | | | | | | | | | | | |  | SEX | | | | | | | |  | | | MARITAL STATUS | | | | | OCCUPATION / JOB TITLE | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | M | MALE | | | | | | | | U | | | UNMARRIED  SINGLE/DIVORCED | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | F | FEMALE | | | | | | | | M | | | MARRIED | | | | | EMPLOYMENT STATUS | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | U | UNKNOWN | | | | | | | | S | | | SEPARATED | | | | |
| PHONE | | | | | | | | | | | | | | | | | # OF DEPENDENTS | | | | | | | | | K | | | UNKNOWN | | | | | NCCI CLASS CODE | | | | | | | | | | | | | | |
| W  A  G  E |  | RATE | | | | | | PER: | | | |  | | DAY | |  | | MONTH | | | | | | | # OF DAYS WORKED/WEEK | | | | | | | FULL PAY FOR DAY OF INJURY? | | | | | | | | | | | |  | | YES | |  | | NO |
|  | | | |  | | WEEK | |  | | OTHER | | | | | | | DID SALARY CONTINUE? | | | | | | | | | | | |  | | YES | |  | | NO |
| O  C  C  U  R  A  N  C  E |  | TIME EMPLOYEE BEGAN WORK | |  | | AM | DATE OF INJURY / ILLNESS | | | | | | | | TIME OF OCCURRENCE | | | | | | | |  | AM | | | LAST WORK DATE | | | | | DATE EMPLOYER NOTIFIED | | | | | | | | | | DATE DISABILITY BEGAN | | | | | | | | | |
|  | | PM |  | PM | | |
| CONTACT NAME / PHONE NUMBER | | | | | | | | | | | | | | | | | | | | TYPE OF INJURY / ILLNESS | | | | | | | | | | | | | PART OF BODY AFFECTED | | | | | | | | | | | | | | | | |
| DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER’S PREMISES? | | | | | | | | | | | | | | | | | | | | TYPE OF INJURY / ILLNESS CODE | | | | | | | | | | | | | PART OF BODY AFFECTED CODE | | | | | | | | | | | | | | | | |
|  |  | | | YES | | |  | | NO | | | | | | | | | | |
| DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | | | | | | | | | | | | | | | | ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | | | | | | | | | |
| SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE  OCCURRED | | | | | | | | | | | | | | | | | | | | | | | | | | | | WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED | | | | | | | | | | | | | | | | | | | | | |
| HOW INJURY OR ILLNESS / ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | CAUSE OF INJURY CODE | | | | | | | | | | | | |
| DATE RETURNED TO WORK | | | IF FATAL, GIVE DATE OF DEATH | | | | | | | | | | WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | YES | | | |  | | NO | | |
| WERE THEY USED? | | | | | | | | | | | | | | | | | | | | | | | |  | | | | YES | | | |  | | NO | | |
| T  R  E  A  T  M  E  N  T |  | PHYSICIAN / HEALTH CARE PROVIDER ( NAME & ADDRESS ) | | | | | | | | | | | | | | | | | HOSPITAL ( NAME & ADDRESS ) | | | | | | | | | | | | | | | | | | INITIAL TREATMENT | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | 0 | | | NO MEDICAL TREATMENT | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | 1 | | | MINOR: BY EMPLOYER | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | 2 | | | MINOR CLINIC/HOSPITAL | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | 3 | | | EMERGENCY CARE | | | | | | | | | | | |
| O  T  H  E  R |  | WITNESS ( NAME & PHONE # ) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 | | | HOSPITALIZED > 24 HRS | | | | | | | | | | | |
| 5 | | | FUTURE MAJOR MEDICAL | | | | | | | | | | | |
| DATE ADMINISTRATOR NOTIFIED | | | | | | | | DATE PREPARED | | | | | | | PREPARER’S NAME & TITLE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |