**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION**

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

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| --- | --- | --- | --- | --- |
| GENERAL |  | 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 #      |
| CARRIER | CLAIMADMIN | 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      |
| EMPLOYEE |  | 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 | UNMARRIEDSINGLE/DIVORCED |  |
|  | F  | FEMALE | M  | MARRIED | EMPLOYMENT STATUS      |
|       | U  | UNKNOWN | S  | SEPARATED |
| PHONE | # OF DEPENDENTS      | K  | UNKNOWN | NCCI CLASS CODE      |
| WAGE |  | RATE      | PER: |   | DAY |   | MONTH | # OF DAYS WORKED/WEEK      | FULL PAY FOR DAY OF INJURY? |   | YES |   | NO |
|  |   | WEEK |   | OTHER | DID SALARY CONTINUE? |   | YES |   | NO |
| OCCURANCE |  | 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 |
| TREATMENT |  | 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 |
| OTHER |  | WITNESS ( NAME & PHONE # ) | 4 | HOSPITALIZED > 24 HRS |
| 5 | FUTURE MAJOR MEDICAL |
| DATE ADMINISTRATOR NOTIFIED      | DATE PREPARED | PREPARER’S NAME & TITLE |