

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)		CARRIER / ADMINISTRATOR CLAIM #	OSHA LOG NUMBER	REPORT PURPOSE CODE			
	PHONE NUMBER		EMPLOYER FEIN	JURISDICTION	JURISDICTION CLAIM NUMBER			
	INSURED REPORT NUMBER		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)		LOCATION #			
	INDUSTRY CODE							
C A R R I E R	C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)		POLICY PERIOD TO	CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)			
		NMPسيا 410 Old Taos Hwy, Santa Fe, NM 87501		CHECK IF APPROPRIATE <input checked="" type="checkbox"/> SELF INSURANCE	CCMSI (Cannon Cochran Management Services Inc.) P.O. Box 30870 Albuquerque, NM 87190 505-837-8700 / 800-635-0679			
		CARRIER FEIN 850365637	POLICY / SELF-INSURED NUMBER	ADMINISTRATOR FEIN 841094892				
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)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE OR (SOC) CODE			
	PHONE NUMBER		# OF DEPENDENTS	EMPLOYMENT STATUS		NCCI CLASS CODE		
	RATE		PER: <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO								
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
	CONTACT NAME / PHONE NUMBER		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED			
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> NO		TYPE OF INJURY / ILLNESS CODE		PART OF BODY AFFECTED CODE			
	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? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT			
					<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED			
WITNESSES (NAME & PHONE #)								
DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE					