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.

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)
«Mun_Title» «NAME»
«Address1»
«City», «State» «Zip»

PHONE NUMBER: «New_Phone»
EMPLOYER FEIN: «Tax_ID»

CARRIER / ADMINISTRATOR CLAIM # | OSHA LOG NUMBER | REPORT PURPOSE CODE
JURISDICTION | JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # | INDUSTRY CODE

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)
New Mexico Self-Insurers' Fund
P.O. Box 846
Santa Fe, NM 87504

POLICY PERIOD: 7/1/05 TO 6/30/06
CHECK IF APPROPRIATE: ☐ SELF INSURANCE
CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN | POLICY / SELF-INSURED NUMBER: «Mun_ID»W | 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)
GENDER: ☐ MALE ☐ FEMALE ☐ UNKNOWN
MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN
OCCUPATION/JOB TITLE OR (SOC) CODE
EMPLOYMENT STATUS
PHONE NUMBER | # OF DEPENDENTS | NCCI CLASS CODE

WAGE

RATE | PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | # DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE ☐ AM ☐ 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? ☐ YES ☐ 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? ☐ YES ☐ NO | WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)
HOSPITAL (NAME & ADDRESS)
INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☐ MINOR CLINIC/HOSPITAL
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HRS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)
DATE ADMINISTRATOR NOTIFIED | DATE PREPARED | PREPARER'S NAME & TITLE

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000 **In-State Toll Free: 1-800-255-7965**

FARMINGTON: 599-9746/1-800-568-7310 **LAS CRUCES:** 524-6246/1-800-870-6826

LAS VEGAS: 454-9251/1-800-281-7889 **LOVINGTON:** 396-3437/1-800-934-2450

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to $1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication ***Guide to Completing the Employer's First Report of Injury or Illness***, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits.*

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).

Center for Medicare/Medicaid Services (CMS) Verification Form

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) requires the New Mexico Self-Insurers' Fund to report specific information contained within this form to the Center for Medicare and Medicaid Services.

In order for us to process your claim, you must complete this form and mail it back to our office so that we may comply with this federal regulation. Please note that the claimant's information will have no effect on the outcome of any claim investigation we conduct and does not imply any liability on behalf of the New Mexico Self-Insurers' Fund and/or its insured.

CLAIMANT INFORMATION			
Last Name		First Name	Middle Initial
Social Security Number - -	Date of Birth / /	Gender ☐ Male ☐Female	
Address			
City		City	Zip
Is the claimant presently, or ever been, enrolled in Medicare, Medicaid or Disability? Medicare ☐ Yes ☐ No Medicaid ☐ Yes ☐ No Disability ☐ Yes ☐No			
If yes, please list the Medicare Claim # from your red, white and blue Medicare card:			
Name of Person Completing This Form if Claimant is Unable (Please Print):			
Last Name		First Name	Middle Initial

I declare and affirm under the penalty of perjury that the answers made herein are true to the best of my knowledge, information and belief.

_____ _____

Signature Print Name

_____ _____

Date Telephone #