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.																
		EMPLOYER (NAME & ADDRESS IN	ICL ZIP)			CAR	RIER / ADMIN	NISTRAT	FOR CLAIM	# OSHA LO	G NUMBER	?	REPORT	PURPC	OSE CODE	
G E						JURI	SDICTION			JUR	ISDICTION	CLAIN	M NUMBE	R		
N E						INSL	JRED REPOR	T NUME	BER							
R						EMP	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)					LOCATION #				
A L		PHONE NUMBER EMPLOYER FEIN										INDUSTRY CODE				
C		CARRIER (NAME, ADDRESS & PHONE NO)				POL	POLICY PERIOD CLAIMS ADMI				NISTRATOR (NAME, ADDRESS & PHONE NO)					
Α	Ç	NMPSIA 410 Old Taos Hwy,					TO CCM				MSI Inon Cochran Management Services Inc.)					
R	CLA-E%	Santa Fe, NM 87501				CHE	CHECK IF APPROPRIATE			P.O. Box 30870 Albuguergue, NM 87190						
R I	» ADM	ALDRICA FEIL					SELF INSURANCE 5			505-837-8700 / 800-635-0679 ADMINISTRATOR FEIN						
E	N N	CARRIER FEIN POLICY / SELF-INSI 850365637					NUMBER		841094892							
R		AGENT NAME & CODE NUMBER														
E		NAME (LAST, FIRST, MIDDLE)				DAT	E OF BIRTH	H SOCIAL SECURITY NUMBER			DATE HIRED STATE OF HIRE					
M P		ADDRESS (INCL ZIP)				GEN	DER MALE	•		ARRIED			PATION/JOB TITLE OR (SOC) CODE			
L							FEMALE		SING	LE/DIVORCED RIED		EMPLOYMENT STATUS				
O Y							UNKNOWN U			SEPARATED						
E		PHONE NUMBER					DEPENDEN	TS	UNKI	NOWN	NCCI CLASS CODE					
W		RATE	PER:	DAY	M	ONTH	# DAYS WO	RKED/W	VEEK	FULL PAY FO	OR DAY OF	INJUF	RY?	YES	NO	
A G E		WEEK U OT							RY CONTINUE? YES NO							
		TIME EMPLOYEE BEGAN WORK AM DATE OF INJURY/ILLNESS TIME OF OCCURR E					NC DATE NO				TE EMPLOYER DATE DISABILITY BEGAN DTIFIED					
0						1	L PM		N500			2407 05 000 4555555				
С		CONTACT NAME / PHONE NUMBER					TYPE OF INJURY/ILLNESS PART					OF BODY AFFECTED				
С		DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? YES NO					TYPE OF INJURY / ILLNESS CODE					PART OF BODY AFFECTED CODE				
U		DEPARTMENT OR LOCATION WHER OCCURRED		ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED												
R																
R		SPECIFIC ACTIVITY THE EMPLOYEE ILLNESS EXPOSURE OCCURRED	OR .	WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED												
E		HOW INJURY OR ILLNESS / ABNOR	MAL HEALTH CO	ONDITION OCCU	JRRED. D	ESCRIB	E THE SEQU	IENCE (OF EVENTS	S AND INCLUE	DE ANY OB	JECTS	OR SUE	3STANC	ES THAT	
N		DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL.														
С													CAUSE (OF INJUI	RY CODE	
E		DATE RETURNED TO WORK IF FATAL, GIVE DATE OF DEATH WERE SAI					FEGUARDS OR SAFETY EQUIPMENT PROVIDED?						YES	3	□ NO	
					WERE T								YES		NO	
T R E		PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)				HOS	HOSPITAL (NAME & ADDRESS)					INITIAL TREATMENT NO MEDICAL TREATMENT				
A T												MINOR: BY EMPLOYER				
M E N									MINOR CLINIC/HOSPITAL EMERGENCY CARE							
0 T H E		WITNESSES (NAME & PHONE #)										HOSPITALIZED > 24 HRS				
												L FUTURE MAJOR MEDICAL/				
		DATE ADMINISTRATOR NOTIFIED DATE PREPARED PRE					PARER'S NAME & TITLE									
R																