# 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 )
NMIMT
Human Resources
801 Leroy Place
Human Resources-Brown Hall
Socorro, NM 87801

PHONE NUMBER: 575-835-5206

EMPLOYER FEIN:

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 )
NMPSIA
410 Old Taos Hwy,
Santa Fe, NM 87501

CARRIER FEIN: 850365637

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☒ SELF INSURANCE

POLICY / SELF-INSURED NUMBER:

CLAIMS ADMINISTRATOR ( NAME, ADDRESS & PHONE NO )
CCMSI
(Cannon Cochran Management Services Inc.)
P.O. Box 30870
Albuquerque, NM 87190
505-837-8700 / 800-635-0679

ADMINISTRATOR FEIN: 841094892

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
Laurel Armijo / 575-835-6935

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.**