**Employer Name & Logo Here**

INTERNAL Workers Compensation First Report of Injury

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EMPLOYER: | | | | | CONTACT: | | | | | | | | CARRIER / FEIN: 850365634 | | | | | | CLAIMS ADMINISTRATOR: | | | | |
|  | | | | |  | | | | | | | | NMPSIA  (New Mexico Public Ins. Authority)  410 Old Taos Hwy.  Santa Fe, NM 87501 | | | | | | CCMSI  (Cannon Cochran Management Services Inc.)  P.O. Box 30980  Albuquerque, NM 97190-0870  Tel 505-837-8700 / 1-800-635-0679 | | | | |
| OCCURANCE OF INCIDENT AND WORK DATES | | | | | | | | | | | | | | | | | | | | | | | |
| *Date of Incident:* | |  | | *Time Incident Occurred:* | | | | | |  | | *Date Last Worked:* | |  | | | *Date Returned to Work:* | | | | | |  |
| SPECIFIC LOCATION OF INCIDENT (School Name, Building, Room Number, hallway, etc.) | | | | | | | | | | | | | | DATE FIRST REPORTED TO EMPLOYER (MM/DD/YYYY) | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | |
| Is there video surveillance of the incident? If so, please save and send to HR Contact.  (Describe Injured Employee’s appearance (hair color, glasses, color of shirt, or anything that would identify them in the video at the time of the incident) | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| INJURED EMPLOYEE NAME | | | | | | | | | | | DATE OF BIRTH  (MM/DD/YYYY) | | | | SOCIAL SECURITY NUMBER  (Full/Complete SSN) | | | | | | GENDER AT BIRTH | | |
| *Last* | | | *First* | | | | *Middle* | | | |  | | | |  | | | | | | Male  Female | | |
|  | | |  | | | |  | | | |
| Work Email & Phone Number | | | | | | | | Personal Email & Phone Number | | | | | | | | Preferred Language: | | | | | | | |
|  | | | | | | | |  | | | | | | | |  | | | | | | | |
| INJURED EMPLOYEE MAILING ADDRESS | | | | | | | | | JOB TITLE | | | | | | | | | DATE OF HIRE (MM/DD/YYYY) | | | | | |
|  | | | | | | | | |  | | | | | | | | |  | | | | | |
| WAGES/SALARY | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | EMPLOYMENT STATUS | | | | | | | | | | |
| Hourly  Weekly  Bi-Weekly  Monthly  Annually | | | | | | | | | | | | | Full-Time  Part Time  Hourly  Other | | | | | | | | | | |
| EMERGENCY CONTACT FOR INJURED EMPLOYEE | | | | | | | | | | | | | | | | | | | | | | | |
| *Name* |  | | | | | *Address* | | |  | | | | | | | | | | | *Phone* | |  | |
| ACCIDENT DESCRIPTION:  - Included Notice of Accident (NOA) with this form. If NOA is illegible or non-English, provide legible English version here. | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| *-* ***COMPLETE*** *INCIDENT INVESTIGATION REPORT*  *-* ***IDENTIFY*** *ANY WITNESSES AND HAVE THEM* ***COMPLETE*** *WITNESS STATEMENT* | | | | | | | | | | | | | | | | | | | | | | | |
| PART(S) OF BODY AFFECTED/ SYMPTOMS: | | | | | | | | | | | | | TYPE OF ACCIDENT (e.g. Fall, Strain, etc.) | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | |
| TREATMENT RECEIVED *OR* PLAN TO RECEIVE | | | | | | | | | | | | | | | | | | | | | | | |
| None  First Aid Only (by self, staff nurse, etc.)  Physician/Health Care Provider  Hospital  Emergency Room/Urgent Care  Transported | | | | | | | | | | | | | | | | | | | | | | | |
| PREPARER’S NAME AND PHONE NUMBER | | | | | | | | | | | | | DATE SUPERVISOR or ADMINISTRATOR NOTIFIED (MM/DD/YYYY) | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | |
| EMPLOYEE’S SIGNATURE AND DATE | | | | | | | | | | | | | SUPERVISOR or ADMINISTRATOR SIGNATURE AND DATE | | | | | | | | | | |
|  | | | | | | | | | | | | |  | | | | | | | | | | |

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| FOR OFFICE USE ONLY |
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