INTERNAL Workers Compensation First Report of Injury

EMPLOYER:	CONTACT:	CARRIER / FEIN: 850365634	CLAIMS ADMINISTRATOR:
NMIMT / Human Resources 801 Leroy Place Human Resources-Brown Hall Socorro, NM 87801 575-835-5206	**Laurel Armijo** New Mexico Tech Human Resources Technician laurel.armijo@nmt.edu 575-835-6935	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 (hair color, glasses, color of shirt, and/or something that would identify them in the video)

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 (see Grab-N-Go Supervisor Packet)*
- ***IDENTIFY*** *ANY WITNESSES AND HAVE THEM* ***COMPLETE*** *WITNESS STATEMENT (see Grab-N-Go Supervisor Packet)*

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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