EMPLOYEE

NAME: Self-explanatory

ADDRESS: Self-explanatory.

PHONE: Self-explanatory

DATE OF BIRTH: Self-explanatory.

DATE HIRED: The date the injured worker began employment with this employer. If there have been multiple periods of employment, enter the beginning date of the current period.

STATE OF HIRE: Self-explanatory.

SEX: Self-explanatory.

MARITAL STATUS: Self-explanatory.

OCCUPATION/JOB TITLE: The worker's occupation at the time of the accident of exposure.

OF DEPENDENTS, EMPLOYMENT STATUS and NCCI CLASS CODE: Not required.

WAGE

RATE: Enter the amount of pre-injury wage in dollars and cents and check the appropriate wage period.

DAYS WORKED/WEEK: The number of the worker's regularly scheduled work days per week.

FULL PAY FOR DAY OF INJURY? Self-explanatory.

DID SALARY CONTINUE? Indicates whether the employer is continuing to pay the worker's regular wages without charge to employee benefits (vacation time, sick days, etc.) during an absence due to the injury.

OCCURRENCE

TIME EMPLOYEE BEGAN WORK: Self-explanatory.

DATE OF INJURY/ILLNESS: For the traumatic injury, enter the date of occurrence. In the case of an occupation 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 possible work-related, whichever is earlier. This item is very important because it is used along with the Social Security number for identification and computer tracking of the First Report information.

TIME OF OCCURRENCE: For a traumatic injury, enter the time at which the accident occurred. Otherwise leave blank.

LAST WORK DATE: The last date the employee actually worked. Do not add days for which the employee was absent from work in a paid status (vacation, comp. time, sick days, etc.).

DATE EMPLOYER NOTIFIED: The date of 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 of illness.

CONTACT NAME/PHONE NUMBER: Name and telephone number of the individual at the employer's premises to be contacted for additional information. Include area code if not in New Mexico.

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).

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? Self-explanatory.

TYPE OF INJURY OR ILLNESS CODE and PART OF BODY AFFECTED CODE: Not required.

DEPARTMENT OR LOCATION: If applicable, specify department or division where the injured worker is regularly employed. 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 code or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all of the equipment, material and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occured. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" for not applicable if no equipment, materials or chemicals were being used. NOTE: The items listed do not have to be directly involving the worker's injury of 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 the worker was 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).

CAUSE OF INJURE CODE: Not required.

DATE RETURNED TO WORK: Complete this block if date is known at the time of filing the E1.

IF FATAL, GIVE DATE OF DEATH: Self-explanatory.

WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED? This refers to safety devices required by law or in general use in the industry.

WERE THEY USED? Self-explanatory

TREATMENT

PHYSICIAN/HEALTH CARE PROVIDER: If worker was treated at the office of a physician or other health care provider, enter the identifying information. This includes an urgent care clinic.

HOSPITAL: If worker was hospitalized or treated at an emergency room, enter the identifying information.

INITIAL TREATMENT: Self-explanatory.

OTHER

WITNESSES: Not required.

DATE ADMINISTRATOR NOTIFIED: The date the claims administrator who is processing the claim received notice of the occurrence.

DATE PREPARED: Self-explanatory.

PREPARER'S NAME AND TITLE: This form must be completed by the employer or the employer's representative, not by the injured worker.