

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

1820 RANDOLPH RD SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

GENERAL	EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER / ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE							
	JURISDICTION				JURISDICTION CLAIM NUMBER				INSURED REPORT NUMBER							
	EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #				PHONE #							
	SIC CODE		EMPLOYER FEIN													
CARRIER	CLAIMS ADMIN	CARRIER (NAME, ADDRESS & PHONE NO)				POLICY PERIOD TO				CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)						
		CARRIER FEIN				POLICY / SELF-INSURED NUMBER				ADMINISTRATOR FEIN						
		AGENT NAME & CODE NUMBER				CHECK IF APPROPRIATE SELF INSURANCE										
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER				DATE HIRED		STATE OF HIRE			
	ADDRESS (INCL ZIP)				SEX M MALE F FEMALE U UNKNOWN		MARITAL STATUS U UNMARRIED SINGLE/DIVORCED M MARRIED S SEPARATED K UNKNOWN		OCCUPATION / JOB TITLE				EMPLOYMENT STATUS			
	PHONE				# OF DEPENDENTS						NCCI CLASS CODE					
WAGE	RATE		PER: <input type="checkbox"/> DAY <input type="checkbox"/> WEEK		MONTH OTHER:		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES <input type="checkbox"/> NO <input type="checkbox"/>		DID SALARY CONTINUE?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
	TIME EMPLOYEE BEGAN WORK		DATE OF INJURY / ILLNESS		TIME OF OCCURRENCE		LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN					
OCCURRENCE	CONTACT NAME / PHONE NUMBER				TYPE OF INJURY / ILLNESS				PART OF BODY AFFECTED							
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> 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 A 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 A 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? WERE THEY USED?				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
TREATMENT	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)				HOSPITAL (NAME & ADDRESS)				INITIAL TREATMENT							
									0 NO MEDICAL TREATMENT							
OTHER	WITNESSES (NAME & PHONE #)								4 HOSPITALIZED > 24 HRS							
	DATE ADMINISTRATOR NOTIFIED				DATE PREPARED		PREPARER'S NAME & TITLE				5 FUTURE MAJOR MEDICAL					

INSTRUCTIONS FOR THE HARD COPY OF THE E1.2

On the hard copy of the E1.2 the shaded blocks may be used at the option of the employer or carrier. They may be beneficial for record-keeping. Examples might include “Insured Report Number,” “Location #,” “Report Purpose Code,” and “Witnesses.” Other blocks may be important for the insurance carrier’s use, such as “Carrier/Administrator Claim Number” or “NCCI Class Code.”

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1.2 may be returned to the sender. Facsimiles of the E1.2 are not accepted by the WCA.

The hard copy of the E1.2 form, with all unshaded spaces completed, is equivalent to the OSHA Form 101 Supplemental Report. You may use the blank space to the left of the OFFICIAL USE box to record the OSHA case or file number (the number which goes on the OSHA 200 log).

NOTE: There may be cases where data that are “Not Required” or are considered “Optional” by the WCA are required to be entered on the OSHA log. Contact the New Mexico Occupational Health and Safety Bureau at 827-2877 with any questions.