

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE i PO BOX 27198
ALBUQUERQUE, NM 87125-7198

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PLEASE PRINT IN BLACK INK OR TYPE.

	EMPLOYER (NAME & ADDRESS INCL ZIP)	CARRIER / ADMINISTRATOR CLAIM #	OSHA LOG NUMBER	REPORT PURPOSE CODE
G E N E R A L		JURISDICTION		