The University of New Mexico

FIRST REPORT OF ACCIDENT—WCA E1.1

RETURN TO: UNM RISK MANAGEMENT DEPARTMENT
ONATE HALL, Room 137

THIS FORM TO BE COMPLETED BY EMPLOYEE AND HIS/HER SUPERVISOR

1. Name of Employer UNIVERSITY OF NEW MEXICO		2. Department name	
3. Department mailing address		4. Department phone # ( )	5. Employee work phone # ( )
6. Name: Last First Middle	7. Male ☐ Female ☐	8. Social security # – –	9. Employee home phone # ( )
10. Home Address	11. City or town	12. State	13. Zip Code
14. Date of birth	15. Age	16. Marital status ☐ Married ☐ Single/ Divorced ☐ Separated ☐ Unknown	17. No. of children under 18 yrs.
18. Date hired	19. No. of hours worked/day	20. No. of days worked/week	21. Normal starting time : ☐ AM ☐ PM
22. Average earnings: hour week bi-week month year $ PER ☐ ☐ ☐ ☐ ☐			
23. Date of injury	24. Time of injury : ☐ AM ☐ PM	25. First date unable to work	26. Was injured paid in full for this day? ☐ YES ☐ NO
27. Did injury occur on employer's premises? ☐ YES ☐ NO			
28. Where did accident, illness, or exposure occur?	29. City or town	30. State	31. Zip Code
32. Occupation when injured	33. Were these normal duties? ☐ YES ☐ NO	34. If no, describe normal duties	
35. If occupational illness, date of diagnosis	36. Estimated time off work From To	37. Date employee returned to work	38. If fatal, date of death
39. Describe in detail how the injury/illness occurred and what the employee was doing when the injury/illness occurred.			
40. Identify objects/substances which directly injured the employee (e.g. machine, vapor, poison, radiation, chemical, etc.)			
41. Describe the nature of the injury or disease in detail and *indicate the part of the body affected (e.g. amputation, broken bone, inhalation, etc.)*			
42. Name, address and phone number of witness(es)			
43. Name & address of physician treating injury/illness	44. Name & address of hospital or facility where treated		

DO NOT WRITE IN THIS COLUMN

Org code
Job code
Location code
Entered by
Date entered

PLEASE COMPLETE REVERSE SIDE.
FORM MUST BE COMPLETED ON BOTH SIDES.

45. DESCRIPTION OF ACCIDENT: Circle the most appropriate description in each category (total of four circles):

Source of Accident (Circle Only one)		Causative Action (Circle Only one)		Body Part Injured (Circle Only one)		Injury Result (Circle Only one)	
Air pollutants	S01	Bite(s), sting(s)	C01	Abdomen, internal organs	4101	Amputation	1001
Blood	S02	Bodily assault	C02	Ankle(s)	5201	Burn, chemical	1301
Bodily motion	S03	Caught in or between	C03	Arms (both)	3181	Burn, heat	1201
Bodily fluid-patient	S04	Contact with:		Arm, lower	3151	Cardiovascular condition	5101
Boxes, barrels, etc.	S05	Flying/falling object(s)	C04	Arm, upper	3111	Concussion	1401
Building structural parts	S06	Hot object(s), substance(s)	C05	Back, lower	4202	Contusion, crushing, bruise	1601
Cart	S07	Stationary object(s)	C06	Back, upper	4201	Cut, laceration, puncture	1701
Chair	S08	Conductive surface(s)	C07	Brain	1101	Damage to prosthetic device	9501
Chemical liquids/vapor	S09	Frayed wire(s)	C08	Buttocks	4402	Dislocation	1901
Cleaning compound(s)	S10	Intact wire(s)	C09	Chest	4301	Electric shock, electrocution	2001
Door	S11	Irritant(s)	C10	Chin	1401	Exposure to:	
Dust, particle(s), chip(s)	S12	Machinery	C11	Ear(s), outside	1211	Chemical(s)	2702
Elevator	S13	Moving object(s)	C12	Ear(s), inside	1241	Contagious agent(s)	1502
Employee	S14	Exposure to:		Elbow(s)	3130	Hepatitis B	3301
Fire, smoke	S15	Chemical(s)	C14	Eye(s)	1301	Hepatitis C	3302
Food	S16	Cold	C15	Face	1481	HIV	2721
Glass	S18	Contagious agent(s)	C16	Finger(s)	3401	Measles	2703
Hand tool (manual)	S19	Heat	C17	Foot or feet	5301	Radiation	2901
Hand tool (power)	S20	Hepatitis B	C18	Groin	4401	Tuburculosis	1571
Heparin lock	S21	Hepatitis C	C19	Hand(s)	3301	Other, specify _____	
Hospital bed	S32	HIV	C20	Head	1001	_____	2704
IM injection	S22	Tuberculosis	C22	Heart	4304	Fracture	2101
Insulin injection	S23	Other, specify _____		Hip(s)	4401	Hearing loss or impairment	2301
IV catheter	S24	_____	C21	Jaw	1411	Heat stroke	2401
IV direct push	S25	Fall from:		Knee(s)	5131	Hernia, rupture	2501
IV piggyback	S26	Chair	C23	Legs (both)	5181	Infection	1501
IV pole	S27	Seat	C24	Leg, lower (calf)	5151	Influenza, pneumonia, asthma	5720
Linen	S28	Vehicle	C25	Leg, upper (thigh)	5111	Joint(s) inflammation	2601
Machinery	S29	Foreign object(s)	C26	Lung(s)	4303	Mental disorder(s)	5401
Office equipment, furniture	S30	Handling trash	C27	Mouth	1442	Multiple injuries	4001
Other, specify _____		Ingestion	C28	Multiple body parts	7001	Needle stick-clean	1702
_____	S99	Inhalation	C29	Neck	2001	Needle stick-contaminated	1703
Patient	S31	Lifting	C30	Non-intact skin	9991	Neoplasm, tumor	5501
Phlebotomy-blood drawing	S35	Needle handling	C31	Nose	1461	Nervous system condition	5601
Sharp instrument	S36	Needle handling trash	C32	Other, specify _____		No illness	8001
Step(s), ladder(s)	S37	Needle resheathing	C33	_____	7001	No injury	9001
Stretcher	S33	Other, specify _____		Ribs	4302	Occupational disease, specify _____	
Syringe handling	S38	_____	C99	Scalp	1501	_____	9901
Vehicle	S39	Pushing/pulling	C34	Shoulder(s)	4501	Other injury, specify _____	
Visitor/other	S40	Repetitive motion:		Skull	1601	_____	9951
Walking/standing surface	S41	Leg(s), arm(s)	C35	Throat	1441	Poisoning	2701
Water	S42	Torso	C36	Thumb(s)	3401	Repetitive stress injury	2651
Wheelchair	S34	Wrist(s)	C37	Toe(s)	5401	Respiratory system condition	5701
		Restraining patient	C38	Tooth or teeth	1443	Scratch(es), abrasion(s)	3001
		Restraining visitor/other	C39	Wrist(s)	3201	Sharp object injury	1704
		Sharp disposal	C40			Skin condition	1891
		Sharp handling trash	C41			Sprain(s), strain(s)	3101
		Sharp object handling	C42			Strangulation	1101
		Shock	C44				
		Slip/trip-no fall	C45				
		Slip/trip/fall:					
		Ladder/scaffolding	C46				
		Same level	C47				
		Stair/ramp	C48				
		Splash/splatter blood	C49				
		Splash/splatter body fluid	C50				
		Twisting torso	C52				

46. Date supervisor knew of injury	47. Was safety device or regulation provided? ☐ YES ☐ NO ☐ N/A	48. Was safety device or regulation used? ☐ YES ☐ NO ☐ N/A	49. Was injury caused by injured's failure to use safety device? ☐ YES ☐ NO ☐ N/A

50. If injury was caused by failure to use safety device, please describe.

51. Supervisor comments

52. Suipervisor Name (Please Print)	53. Date	54. Supervisor phone #

55. Supervisor's Signature	56. Supervisor title

57. Employee Signature	58. Date