THE UNIVERSITY of NEW MEXICO
Department of Safety & Risk Services

FAX# (505) 277-9006

FIRST REPORT OF ACCIDENT – WCA E1.1

RETURN TO:UNM SAFETY AND RISK SERVICES BUILDING 233

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 the accident, illness, or exposure occur?		29. City or Town	30. State: NM	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.

FORM E1.1 REVISED 03/2012

Mailstop Code: MSC07 4100

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)	
Airpollutants	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:Chemical(s)	C14	Elbow(s)	3130	Hepatitis B	3301
Fire, smoke	S15	Cold	C15	Eye(s)	1301	Hepatitis C	3302
Food	S16	Contagious agent(s)	C16	Face	1481	HIV	2721
Glass	S18	Heat	C17	Finger(s)	3401	Measles	2703
Hand tool (manual)	S19	Hepatitis B	C18	Foot or feet	5301	Radiation	2901
Hand tool (power)	S20	Hepatitis C	C19	Groin	4401	Tuburculosis	1571
Heparin lock	S21	HIV	C20	Hand(s)	3301	Other,specify_____	2704
Hospital bed	S32	Tuberculosis	C22	Head	1001	Fracture	2101
IM injection	S22	Other,specify_____	C21	Heart	4304	Hearing loss or impairment	2301
Insulin injection	S23	Fall from:Chair	C23	Hip(s)	4401	Heat stroke	2401
IV catheter	S24	Seat	C24	Jaw	1411	Hernia, rupture	2501
IV direct push	S25	Vehicle	C25	Knee(s)	5131	Infection	1501
IV piggyback	S26	Foreign object(s)	C26	Legs (both)	5181	Influenza, pneumonia, asthma	5720
IV pole	S27	Handlingtrash	C27	Leg, lower (calf)	5151	Joint(s) inflammation	2601
Linen	S28	Ingestion	C28	Leg, upper (thigh)	5111	Mental disorder(s)	5401
Machinery	S29	Inhalation	C29	Lung(s)	4303	Multiple injuries	4001
Office equipment, furniture	S30	Lifting	C30	Mouth	1442	Needle stick—clean	1702
Other, specify_____ ___ _____ S99		Needle handling	C31	Multiple body parts	7001	Needle stick—contaminated	1703
		Needle handling trash	C32	Neck	2001	Neoplasm, tumor	5501
		Needle resheathing	C33	Non-intact skin	9991	Nervous system condition	5601
		Other, specify_____	C99	Nose	1461	No illness	8001
Patient	S31	Pushing/pulling	C34	Other,specify_____	7001	No injury	9001
Phlebotomy—blood drawing	S35	Repetitive motion:		Ribs	4302	Occupational disease,	
Sharp instrument	S36	Leg(s), arm(s)	C35	Scalp	1501	specify_____	9901
Step(s), ladder(s)	S37	Torso	C36	Shoulder(s)	4501	Other injury,	
Stretcher	S33	Wrist(s)	C37	Skull	1601	specify_____	9951
Syringe handling	S38	Restraining patient	C38	Throat	1441	Poisoning	2701
Vehicle	S39	Restraining visitor/other	C39	Thumb(s)	3401	Repetitive stress injury	2651
Visitor/other	S40	Sharp disposal	C40	Toe(s)	5401	Respiratory system condition	5701
Walking/standing surface	S41	Sharp handling trash	C41	Tooth or teeth	1443	Scratch(es), abrasion(s)	3001
Water	S42	Sharp object handling	C42	Wrist(s)	3201	Sharp object injury	1704
Wheelchair	S34	Shock	C44			Skin condition	1891
		Slip/trip—no fall	C45			Sprain(s), strain(s)	3101
		Slip/trip/fall:				Strangulation	1101
		Ladder/scaffolding	C46				
		Same level	C47				
		Stair/ramp	C48				
		Splash/splatter blood	C49				
		Splash/splatter body fluid	C50				
		Twisting torso	C52				
Enter Accident Code		Enter Action Code		Enter Injury Code		Enter Results Code	

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

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

51.Supervisor comments

52.Supervisor Name(Please Print)	53. Supervisor UNM NetID	54. Date	55. Supervisor phone #

56. Supervisor's Signature	57. Supervisor title

58. Employee Signature	59. Date