

Can be used for any claim except WORKERS' COMPENSATION
NOTICE OF INCIDENT – STATE OF NEW MEXICO
(Fill out this form in detail)
Please print or type

Location Code: _____

**Time, Date and Place of
Incident**

Dept./Div. _____ Div. Address _____

Div. Contact Person _____ Phone No. _____

Employee Involved _____ Phone No. _____

Date _____ Time _____ a.m. _____ p.m. _____

Location of Incident _____

Injured Person

Full Name _____ Age _____

Address _____ Phone No. _____

Employed by _____

Injuries _____

Treated by _____

Address _____

Owner of Property Damaged

Full Name _____ Phone No. _____

Address _____

Description of Property Damaged _____

Witnesses

Name _____

Address _____ Phone No. _____

Name _____

Address _____ Phone No. _____

Description of Incident

Please describe incident



Date _____

Reported by _____

Dept./Div. _____



