NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

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

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)
New Mexico State University
P.O. Box 30001, Dept. 5273
Las Cruces, NM 88003

PHONE NUMBER: 505-646-7375
EMPLOYER FEIN: 85-6000401

CARRIER / ADMINISTRATOR CLAIM #
OSHA LOG NUMBER
REPORT PURPOSE CODE
JURISDICTION
JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)
LOCATION #
INDUSTRY CODE

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)
Worker's Compensation Bureau
Risk Management Division
P.O. Box 6850
Santa Fe, NM 87502

POLICY PERIOD
TO
☐ CHECK IF APPROPRIATE SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Risk Management Division
1100 St. Francis Dr.
Santa Fe, NM 87502

CARRIER FEIN: 85-6000565
POLICY / SELF-INSURED NUMBER
ADMINISTRATOR FEIN: 85-6000565
AGENT NAME & CODE NUMBER

EMPLOYEE

NAME (LAST, FIRST, MIDDLE)
DATE OF BIRTH
SOCIAL SECURITY NUMBER
DATE HIRED
STATE OF HIRE: NM

ADDRESS (INCL ZIP)

GENDER: ☐ MALE ☐ FEMALE ☐ UNKNOWN

MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN

OCCUPATION/JOB TITLE OR (SOC) CODE
EMPLOYMENT STATUS

PHONE NUMBER (H) (W)
OF DEPENDENTS
NCCI CLASS CODE

WAGE

RATE
PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER:
DAYS WORKED/WEEK
FULL PAY FOR DAY OF INJURY? ☒ YES ☐ NO
DID SALARY CONTINUE? ☒ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK ☐ AM ☐ PM
DATE OF INJURY/ILLNESS
TIME OF OCCURRENCE ☐ AM ☐ PM
LAST WORK DATE
DATE EMPLOYER NOTIFIED
DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER
(Supv).
TYPE OF INJURY/ILLNESS
PART OF BODY AFFECTED

DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? ☒ YES ☐ 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 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 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? ☐ YES ☐ NO
WERE THEY USED? ☐ YES ☐ NO

TREATMENT

PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)
HOSPITAL (NAME & ADDRESS)

INITIAL TREATMENT
☐ NO MEDICAL TREATMENT
☐ MINOR: BY EMPLOYER
☒ MINOR CLINIC/HOSPITAL
☐ EMERGENCY CARE
☐ HOSPITALIZED > 24 HRS
☐ FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED

OTHER

WITNESSES (NAME & PHONE #)

DATE ADMINISTRATOR NOTIFIED
DATE PREPARED
PREPARER'S NAME & TITLE

NM WCA FORM E1.2 EQUIVALENT TO OSHA'S FORM 301 FORM IA-1 (7/02) © IAIABC 2002

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACION DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 ,Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, _____, was involved in an on-the-job accident or was disabled
Yo, (name of employee/*nombre del empleado*) *me lastimé en un accidente en el trabajo o fui incapacitado*

by an occupational disease at approximately _____, on _____, 20____.
por enfermedad de oficio aproximadamente (time/*a la(s) hora(s)*) *el* (date/*fecha*) *del* 20____.

Employee's social security number: _____ Where did the accident occur? _____
Número de suguro social del empleado: *¿Dónde ocurrió el accidente?*

What happened? _____
¿Qué ocurrió?
_____
_____

To be completed by Employer:	**Worker will choose health care provider. Yes___ No___**
Completado por el empleador:	*Trabajador elegir proveedor de atención médica.*
If Yes, Employer has right to change health care provider after 60 days.	**If No, Worker has the right to change health care provider after 60 days.**
En caso afirmativo, el empleador tiene derecho a cambier de proveedor de atención médica después de 60 dias.	*En caso que no elige, el trabajor tiene derecho a cambiar de proveedor de atención médica después de 60 dias.*
WORKER MUST INITIAL____	***INICIALES DEL TRABAJADOR***

Signed: _____ Signed/Notice Received: _____
Firma: (employee/*empleado*) *Firma/Notificación recibida:* (employer or representative/*empleador o representante*)
Date/Fecha: _____ Date/*Fecha*: _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Worker --
For emergency medical care, go to any emergency medical facility.

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador
Para emergencias médicas vaya a cualquier clinica / hospital.

Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de dias festivos.

Statewide Helpline -- *Linea de Asistencia*

1-866-WORKOMP / 1-866-967-5667

toll free -- *llamada sin costo de larga distancia*

New Mexico Workers' Compensation Administration
PO Box 27198, Albuquerque, NM 87125

Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 568-7310
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Lovington: (575) 396-3437 - 1 (800) 934-2450
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381
TDD for the deaf: (505) 841-6043
www.workerscomp.state.nm.us

Employer/employee: Each keep one copy.
Empleador/empleado: Retener una copia.

Form NOA-1-W (4/12)

WORKERS' COMPENSATION
CLAIM EXPLANATION

In reporting this alleged on-the-job injury/occupational illness, which occurred on _____.
I, the undersigned, acknowledge the following items have been explained to me and that I understand each item.

1. By reporting this injury/illness to my supervisor or other designated person I am only complying with requirements of my agency's internal loss prevention procedures and the New Mexico Workers' Compensation Act. _____ (Initials)
2. Reporting the injury/illness does not automatically qualify me for Workers Compensation benefits. _____ (Initials)
3. My employer has the right to either direct me to a health care provider of their choice upon the report of this accident or permit me to select my own health care provider for treatment of my alleged job-incurred injury/illness. I am fully aware that unauthorized treatment may not be a covered Workers' Compensation benefit.

   Choose one and sign.

   A. My employer chooses to select the health care provider for the first 60 days.

   _____ _____
   (Name of Physician) (Employee Signature)

   B. My employer will permit me to select the health care provider for the first 60 days.

   _____ _____
   (Name of Physician) (Employee Signature)

4. This injury will be investigated by my agency and Risk Management Division, who will determine if the injury/illness qualifies under the guidelines of the Workers' Compensation Act. _____ (Initials)
5. I will be advised by proper authority if particular investigative circumstances or facts **AT THE AGENCY LEVEL** cause the investigating person(s) to believe that the injury/illness is **NOT** within the purview of the Workers Compensation Act. If I am not satisfied with the determination at the agency level, I am aware that I may request reconsideration of my claim by the assigned Workers Compensation Claims Administrator at Risk Management Division at (505) 827-0232. _____ (Initials)
6. My supervisor or a designated agency representative (_____) will be promptly informed of all doctors' appointments, diagnosis/prognosis, billings and/or changes in treatment. _____ (Initials)

All information stated by me regarding this incident, to any person investigating said incident or representing my employer, is true and factual. Any willful untruths or misrepresentations regarding an alleged on-the-the job injury/illness will be regarded as falsification of official documents.

_____
Print name of Employee

_____
Print name of witness

_____
Signature of Employee

_____
Signature of witness

_____
Date

_____
Date

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS

Worker/Patient FULL NAME: _____ DOB: _____ SSN: XXX-XX-____

FOR WCA REFERENCE ONLY: Date/s of Injury: _____ WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with NMSA 1978, § 52-10-1, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any work place injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed $1.00 per page for the first ten (10) pages or up to twenty-cents ($0.20) for each page thereafter. A copy of this authorization may be used as an original.

Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman.

RELEASE OF HEALTH CARE RECORDS

I, (Print Worker's Name) _____, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility: _____
Address: _____
_____
_____

I authorize the following records released (check box, as appropriate): ☐ **ALL RECORDS** / ☐ **SPECIFIC DATES** (provide a date range for records authorized to be released (_____)

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (initial any that may apply).

____Treatment for alcohol and/or substance abuse ____Sexually transmitted diseases _____ HIV or AIDS
____Behavioral or Mental Health, including Psychiatric or Psychological
____Records of the Department of Health Medical Cannabis Program

_____ _____
Signature of Worker/Patient/Personal Representative Date

PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be ☐ Picked Up ☐ Mailed ☐ Emailed ☐ Faxed ☐ Other (specify) _____

Authorized Recipient/s: _____
Address: _____
_____
_____
Fax/Email: _____

EXPIRATION and CONDITIONS

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFIYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

_____ _____
Signature of Worker/Patient Date

_____ _____
Signature of Personal Representative (if any) Date

_____ _____
Printed Name of Personal Representative Relationship to Worker/Patient

Revised 7/26/16

WORKERS' COMPENSATION
BENEFITS EXPLANATION FORM

I,_____, acknowledge that the following items have been explained to me and that I do understand each item.

1. §10-7-13 NMSA prohibits public employees from receiving monthly salary for leave time in combination with workers' compensation benefits that exceeds 100% of the employee's monthly base salary. _____ (initials)

2. The workers' compensation benefit is computed at 66⅔% of the employee's gross weekly base salary **UP TO A SPECIFIED CAP** For most individuals, this figure is equal to the pay received in 5.3 hours of the normal 8 hour work day and is recorded as Workers' Compensation Leave Without Pay (LWOP). The remaining 2.7 hours are charged to sick and/or annual leave or authorized LWOP. _____ (initials)

3. Unusual deductions such as private medical, dental, and legal insurance can continue as long as the remaining 2.7 hours (or more) per day are taken as sick and/or annual leave. If an employee runs out of sick and/or annual leave, the employee must bear the burden of paying his/her and the state's share of such deductions, unless the employee applies, and is approved for, leave under the Family and Medical Leave Act (FMLA). _____ (initials)

4. The first 5 work days (40 hours, 7 calendar days) that an employee loses time is **NOT** compensated until the employee has been off work for more than 28 calendar days. The first week is initially charged to sick and/or annual leave or authorized LWOP. _____ (initials)

5. After 28 calendar days off work, the first week's benefit check is paid. At this time, unless the employee was on LWOP, or in other words, did not have or use any sick or annual leave for that first 40 hours, the first week's benefit check will constitute an overpayment and violates §10-7-13 NMSA. Therefore, the employee must reimburse the agency for the amount of overpayment received. In return, the agency must reinstate the applicable amount of sick and/or annual leave used during the first week. _____ (initials)

6. The amount of overpayment will be computed by the agency upon receipt of the first week's check. Should the check be delivered **DIRECTLY** to the employee, it is the employee's responsibility to ensure proper procedures are followed. _____ (initials)

7. The responsibility for properly coding time sheets rests with the immediate supervisor. The injured employee must also ensure that time sheets are properly and accurately prepared. _____
(initials)

8. Any LWOP time in excess of 30 days, **INCLUDING THAT USED FOR WORKERS' COMPENSATION PURPOSES**, does not allow an individual to accrue service time towards retirement, unless the employee applies, and is approved for FMLA. All other LWOP time must be made up by actual service (productive) time. _____
(initials)

_____
Print name of injured employee

_____
Signature of injured employee

_____
Date

WITNESS:

_____
Name

_____
Date