RISK SERVICES

Notice to Injured Employee

In order to file a Workers Compensation claim, you will need to review and sign the forms included in this document. All five forms must be sent to Risk Services for claim filing. **Your claim will not be submitted until all five forms are received by Risk Services.** If you choose to complete these forms by hand, please ensure all writing is legible. Forms may be submitted via email or in person at the Risk Services.

*Please have your supervisor sign the second signature line on the right of the Notice of Accident or Occupational Disease Disablement form.

**Please be advised completing and submitting your forms does *not* guarantee your injury/illness claim is accepted by the state. An adjuster will contact you regarding the claim's acceptance or denial.

Risk Services 505-273-1573
Mailing Address:
MSC01 1210
1 University of New Mexico
Albuquerque, NM 87131
Physical Location:
John and June Perovich Business Center
Suite 2400
claims@unm.edu

RISK SERVICES

FIRST REPORT OF ACCIDENT – WCA E1.1

RETURN TO:UNM RISK SERVICES
JOHN & JUNE PEROVICH BUSINESS CENTER, SUITE 2400

THIS FORM TO BE COMPLETED BY EMPLOYEE AND SUPERVISOR

1.Name of Employer	2. Department Name
University of New Mexico	

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	17. No. of children under 18 yrs.
		Married ☐ Single/Divorced ☐ Separated ☐ Unknown ☐	

18. Date Hired	19. No. of hours worked/day	20. No. of days worked/week	21. Normal starting time	22. Average earnings: hour week bi-week month year
			☐ AM ☐ PM	$ PER ☐☐☐☐☐

23. Date of injury	24. Time of injury	25. First date unable to work	26. Was injured paid in full for this day?	27. Did injury occur on employer's premises?
	☐ AM ☐ PM		☐ YES ☐ NO	☐ YES ☐ NO

28. Where did the accident, illness, or exposure occur?	29. City or Town	30. State	31. Zip Code
		NM	

32. Occupation when injured	33. Were these normal duties?	34. If no, describe normal duties
	☐ YES ☐ NO	

35. If occupational illness, date of diagnosis	36. Estimated time off work	37. Date employee returned to work	38. If fatal, date of death
	From To		

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 11/2021

Mailstop Code: MSC01 1210

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? ☐ YES ☐ NO ☐ N/A	48. Was safety device or regulation used? ☐ YES ☐ NO	49. Was injury caused by injured's failure to use safety device? ☐ 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

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 X**
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)

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:	UNM Risk Services	NM State Risk Management Division
Address:	1 University of NM (MSC 01 1210)	PO Box 6850
	Albuquerque, NM 87131	Joseph Montoya Bldg., RM 2073 Santa Fe, NM 87502
	(505)-273-1573	(505)-872-2711
Fax/Email:	(505)-277-7662 riskscvs@unm.edu	(505)-827-0685

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 11/2021

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.
   Employee Occupational Health Services _____
   (Name of Physician) (Employee Signature)

   B. My employer will permit me to select the health care provider for the first 60 days.
   N/A N/A
   _____ _____
   (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

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 66 2/3% 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_____