NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACIÓN 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 seguro social del empleado: *¿Dónde ocurrió el accidente?*

What happened?_____
¿Qué ocurrió?

_____

_____

To be completed by Employer:
Completado por el empleador:
If Yes, Employer has right to change health care provider after 60 days.
En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.

Worker will choose health care provider. Yes X_ No___
Trabajador elegirá proveedor de atención médica.
If No, Worker has the right to change health care provider after 60 days.
En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.

WORKER'S INITIALS ____ ***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

Form NOA-1 **Employer/employee: Each keep one copy.** **Empleador/empleado: Retener una copia.** **----SEE BACK OF THIS FORM----** **----VER AL REVERSO DE ESTA FORMA--**

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
Hobbs: (575) 397-3425 - 1 (800) 934-2450
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381

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 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 11/2021

Mailstop Code: MSC01 1210