All School sites must have a designated Worker's Compensation designee. Please provide Jani Nail jnail@gmcs.k12.nm.us with the name of your school site Worker's Compensation designee.

READ THE FOLLOWING CAREFULLY – PLEASE NOTE, THE FORM MUST BE FILLED OUT AT THE WORK SITE.

INCOMPLETE AND INCORRECT PACKET/FORMS WILL BE RETURNED TO THE PRINCIPAL.

Emergency Medical Treatment: **If emergency care is needed, get that first! If more than basic first aid is needed – have them go to a clinic or the emergency room immediately!**

When an injury or illness is life threatening in nature, the injured worker **shall** seek emergency treatment at the nearest emergency facility or by calling 911. **After** the emergency has abated, the injured worker will notify the Principal or Immediate Supervisor in writing of the work related injury and presents any disability or return to work notices.

Items highlighted in BLUE must be filled out by the employee
Items highlighted in YELLOW, must be filled out by the Principal or the Worker's Compensation designee

Reporting Accidents and filling out the packet;

Page 1 – Information cover sheet

Page 2 – **Notice of accident form to be filled out by the Employee. All work-related accidents or injuries must be reported immediately to the injured employee's supervisor by completing and submitting the Notice of Accident form (NOA), whether or not medical care is needed. This must be signed by both the employee and the Principal or Immediate Supervisor**

Page 3 - Employers' first report of Accident form to be **filled out by** the **Administrator or work site designated Worker's Compensation person**

Page 4 - Use & Disclosure of health records form – must be filled out and signed by the employee

Page 5 – **The Employee must fill out and sign the sick leave choice form. This form lets the employee know they will NOT be compensated for the first five (5) days and must use accrued leave**

Workers' Compensation Rule 11.4.3.13B.4. (see below for condensed quote) documents that the employer has 72 hours to send the First Report a WC claims administrator. This means that once the worker presents notice to the supervisor or other person designated that takes WC notices, GMCS has 72 hours to report it to CCMSI.

http://www.workerscomp.state.nm.us/pdf/rules/rule3.pdf
11.4.3.13 CONDUCT OF PARTIES:
B. Employer's duties:
(4) **The employer shall report every accident** to their insurer or, in the case of a self-insured employer or member of a self-insurance group, their claims administrator, whether or not the employer considers the claim to be valid, **within 72 hours of the earlier of:**
(a) **actual knowledge of the accident by the employer; or**
(b) **presentation of a notice of accident form to the employer**.

The Employer's First Report of Injury or illness must be submitted within 72 hours from the time the supervisor was informed of the accident to the employer's designated Workers' Compensation benefit specialist – **Jani Nail in Personnel**. Jani, the Workers' Compensation benefit specialist, will then submit the information online and obtain the claim number.

If you have any questions or concerns, please email or call. I am constantly checking my email and respond faster via email.

Thank you,
Jani Nail

Jani Nail
Personnel Assistant
FMLA-Licensure-Workers' Comp-SLB - Sick Leave Bank
Telephone: (505)721-1143
FAX: (505)721-1142
Student Support Center
GALLUP MCKINLEY COUNTY SCHOOLS

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000 **In-State Toll Free: 1-800-255-7965**

FARMINGTON: 599-9746/1-800-568-7310 **LAS CRUCES:** 524-6246/1-800-870-6826

LAS VEGAS: 454-9251/1-800-281-7889 **LOVINGTON:** 396-3437/1-800-934-2450

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to $1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication ***Guide to Completing the Employer's First Report of Injury or Illness***, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits.*

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).

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: **Worker will choose health care provider. Yes___ No___**
Completado por el empleador: *Trabajador elegirá 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 cambiar de proveedor de atención médica después de 60 dias. *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 (9/17) **Employer/employee: Each keep one copy.** **----SEE BACK OF THIS FORM----**
Empleador/empleado: Retener una copia. **----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

www.workerscomp.nm.gov

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)

CARRIER / ADMINISTRATOR CLAIM # | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE NUMBER | EMPLOYER FEIN | INDUSTRY CODE

CARRIER

CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)
NMPSIA
410 Old Taos Hwy,
Santa Fe, NM 87501

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☒ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CCMSI
(Cannon Cochran Management Services Inc.)
P.O. Box 30870
Albuquerque, NM 87190
505-837-8700 / 800-635-0679

CARRIER FEIN
850365637

POLICY / SELF-INSURED NUMBER

ADMINISTRATOR FEIN
841094892

AGENT NAME & CODE NUMBER

EMPLOYEE

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

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 | # 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 | 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

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

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 Section 52-10-1 NMSA 1978, 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 formularia, póngase en contacto con un ombudsmon (866) 967-5667.

RELEASE OF HEALTH CARE RECORDS

I, (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:		
Telephone No.:		

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: (check 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:		
Telephone No.:		
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 THAT 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

GALLUP-McKINLEY COUNTY PUBLIC SCHOOLS
GALLUP, NEW MEXICO

TIM BOND
Assistant Superintendent of Support Services

SANDRA K. LEE
Director of Personnel

K'DAWN MONTANO
Personnel Coordinator

USE OF SICK LEAVE FOR A WORK RELATED INJURY

If the employee must use any accrued sick leave for the first five (5) working days due to Workman's Compensation injury/illness, they may elect one of the following options:

1. Employee may elect to go on Worker's Compensation Leave Without Pay Status (WCLWOP). This means the employee only receives payment from Worker's Compensation equal to 2/3 of the employee's daily rate or;

2. Employee may elect to utilize accrued sick leave or other qualifying District leave benefits and retain full salary. Sick (or other) leave will be deducted at 1/3 day per actual day missed, beginning on the 6th work day missed due to Worker's Compensation injury/illness.

All leave will run concurrently with FMLA

Choose an option:

_____ I choose to go on Worker's Compensation Leave Without Pay status. I understand that I will only receive payments from Worker's Compensation equal to 2/3 of my daily rate.

_____ I choose to utilize my accrued sick (or other qualifying) District leave and retain full salary. My sick leave Will be deducted at 1/3 day per actual day missed. I agree to endorse my Worker's Compensation checks Over to the District. I have sufficient sick leave accrued.

_____
Signature

_____
Printed Name

_____
Date and Work Site

P.O. Box 1318 640 South Boardman Drive Gallup, New Mexico 87305-1318
(505) 721-1068 FAX (505) 721-1134