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)

PHONE NUMBER

EMPLOYER FEIN

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)

NMAC

POLICY PERIOD

TO

CHECK IF APPROPRIATE

☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY / SELF-INSURED NUMBER

ADMINISTRATOR FEIN

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

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
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
NOTIFICACION DE ACCIDENTE O ENFERMEDAD DE OFICIO

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

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 the right to change health care provider after 60 days.
En caso afirmativo, el empleador tiene derecho a cambier de proveedor de atenciòn mèdica despuès de 60 dias.

Worker will choose health care provider. Yes___ No___
Trabajador elegir proveedor de atenciòn mèdica.
If No, Worker has the right to change health care provider after 60 days.
En caso que no elige, el trabajor tiene derecho a combiar de proveedor de atenciòn mèdica despès de 60 dias.

Signed: _________________________
Firma: (employee/empleado)

Signed/Notice Received: ____________________________
Firma/Notificación recibida (employer or representative/empleador o representante)

Date/Fecha: _____________________ Date/Fecha: _________________

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

Worker—
For emergency medical care, go to any emergency medical facility. Emergency medical care will not constitute a selection of health care provider.
For medical care that is not an emergency, get instructions from your supervisor on where to go for medical care. If you have initial selection of health care provider as indicated above, you may select a provider of your choosing and will be paid for by the employer consistent with the terms of the Workers' Compensation Act.

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 thru Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador—
Para emergencies médicas vaya a cualquier clínica / hospital. Atención médica de emergencia no constituirá una selección de proveedor de atención médica.
Para tratamiento medico que no sea emergencia, obtenga instrucciones de su supervisor para que le indique a donde ir para obtener asistencia médica. Si usted tiene la selección inicial del profesional de la salud como se indicó anteriormente, es posible seleccionar un proveedor de su elección y será pagado por el empleador consistente con los términos de la Ley de Compensación de los Trabajadores.

Trabajadores 7 empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualiquier oficina de la Administración de la Compensación de los Trobajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hast alas 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 Las Vegas: (505) 454-9251 - 1(800) 281-7889 Santa Fe: (505)476-7381
Farmington: (505) 599-9746 - 1(800) 568-7310 Lovington: (575)396-3437 - 1(800) 934-2450 TDD for the deaf: (505)841-6043
Las Cruces: (505)524-6246 - 1(800)870-6826 Roswell: (575)623-3997 – 1(866) 311-8587 www.workerscomp.state.nm.us

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

Form NOA-1-W (4/12)

NMCIA
3. SUPERVISOR'S REPORT OF ACCIDENT

County: ______________________ Department: ______________________
Employee Name: ______________________ Date: ______________________

JOB CLASSIFFICATION

- ☐ Administration/Clerical
- ☐ Animal Control
- ☐ Custodian
- ☐ Detention Officer/Supervisor
- ☐ EMT/Paramedic
- ☐ Equipment Operator
- ☐ Field Worker/Crew Member
- ☐ Firefighter (Paid or Volunteer)
- ☐ Law Enforcement Officer/Supervisor
- ☐ Maintenance Worker
- ☐ Mechanic
- ☐ Supervisor
- ☐ Truck Driver
- ☐ Welder
- ☐ Other ______________________

TYPE OF CONTACT

- ☐ Animal
- ☐ Assault, e.g., offender assaults
- ☐ Caught In, On, Between, or Under
- ☐ Contact With, e.g. bloodborne pathogen, chemical, noise, weather extremes, etc.
- ☐ Fall from Elevation, e.g., different height
- ☐ Fall from same Level
- ☐ Motor Vehicle Accident
- ☐ Overexertion, e.g., strains, ergonomic, etc.
- ☐ Struck By or Against
- ☐ Other ______________________

Form to be completed by injured/affected employees' supervisor.

CAUSE(S)

Unsafe Act(s)

- ☐ Failure to use PPE
- ☐ Horseplay/misuse
- ☐ Improper lifting/loading
- ☐ Operation without authority/training
- ☐ Working on equipment in operation
- ☐ Other ______________________

Unsafe Condition(s)

- ☐ Defective tools, equipment, or material
- ☐ Fire & explosion hazard
- ☐ Inadequate engineering controls
- ☐ Inadequate guards or barriers
- ☐ Inadequate illumination
- ☐ Inadequate or improper PPE
- ☐ Inadequate maintenance
- ☐ Inadequate supervision
- ☐ Inadequate warning system
- ☐ Inadequate ventilation
- ☐ Lack of experience (skill)
- ☐ Lack of knowledge (training)
- ☐ Poor housekeeping
- ☐ Other ______________________

Event Description: ____

____

____

____

____

____

____

____

Does County/Department have policy or procedure for this activity? **YES** **NO**

If so, was the policy or procedure followed? **YES** **NO**

PREVENTATIVE MEASURES TAKEN

- ☐ Counsel/sanction employee/supervisor
- ☐ Repair tool, equipment, or material
- ☐ Improve design or layout
- ☐ Improve housekeeping
- ☐ Improve maintenance
- ☐ Provide proper PPE
- ☐ Train employee
- ☐ Train supervisor
- ☐ No Action Practical
- ☐ Other ______________________________

Policy/Procedures

- ☐ Develop new policy/procedure
- ☐ Enforce policy/procedure
- ☐ Revise policy/procedure

What action was taken to prevent similar occurrences? ______________________________

____

____

____

____

____

Supervisor Name: ______________________________ Date: ____________________

Employee Signature: ____________________________ Date: ____________________

Loss Prevention Coordinator and/or Safety Committee Concurrence: **YES** **NO**

NMCIA
4. WITNESS STATEMENT OF ACCIDENT

FORM IS TO BE COMPLETED BY THE INVOLVED WITNESS AND FORWARDED TO RISK MANAGEMENT WITHIN TWO (2) WORKING DAYS OF THE OCCURANCE.

Accident of: ____________________________ Date of Accident: ___________________________
(Name of person who had accident)

Name of Witness: ______________________ Employer: ________________________________

Date of Statement: ____________________ Time of Statement: ________________________

Home Phone #: _______________________ Work Phone #: ____________________________

Home Address: ____

Location of Accident: ____

____

Describe the accident or incident in your own words and just as you saw it happen:

____

____

____

____

____

____

____

____

____

____

____

______________________________________ ______________________________
Witness's Signature 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