



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 fax, email, or in person at the Risk Services.

****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

risksvcs@unm.edu

THIS FORM TO BE COMPLETED BY EMPLOYEE AND HIS/HER SUPERVISOR

1. Name of Employer University of New Mexico				2. Department Name				
3. Department Mailing Address			4. Department Phone#			5. Employee Work Phone #		
6. Name: Last		First		Middle	7. Male <input type="radio"/>	Female <input type="radio"/>	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 <input type="radio"/> Single/Divorced <input type="radio"/> Separated <input type="radio"/> Unknown <input type="radio"/>				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 <input type="radio"/> AM <input type="radio"/> PM			22. Average earnings: hour week bi-week month year \$ PER <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>		
23. Date of injury	24. Time of injury <input type="radio"/> AM <input type="radio"/> PM		25. First date unable to work	26. Was injured paid in full for this day? <input type="radio"/> YES <input type="radio"/> NO		27. Did injury occur on employer's premises? <input type="radio"/> YES <input type="radio"/> 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? <input type="radio"/> YES <input type="radio"/> 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

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	Tuberculosis	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_____		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
S99		Pushing/pulling	C34	Other,specify_____	7001	No injury	9001
Patient	S31	Repetitive motion:		Ribs	4302	Occupational disease, specify_____	9901
Phlebotomy—blood drawing	S35	Leg(s), arm(s)	C35	Scalp	1501	Other injury, specify_____	9951
Sharp instrument	S36	Torso	C36	Shoulder(s)	4501	Poisoning	2701
Step(s), ladder(s)	S37	Wrist(s)	C37	Skull	1601	Repetitive stress injury	2651
Stretcher	S33	Restraining patient	C38	Throat	1441	Respiratory system condition	5701
Syringe handling	S38	Restraining visitor/other	C39	Thumb(s)	3401	Scratch(es), abrasion(s)	3001
Vehicle	S39	Sharp disposal	C40	Toe(s)	5401	Sharp object injury	1704
Visitor/other	S40	Sharp handling trash	C41	Tooth or teeth	1443	Skin condition	1891
Walking/standing surface	S41	Sharp object handling	C42	Wrist(s)	3201	Sprain(s), strain(s)	3101
Water	S42	Shock	C44			Strangulation	1101
Wheelchair	S34	Slip/trip—no fall	C45				
		Slip/trip/fall:					
		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? <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> N/A	48. Was safety device or regulation used? <input type="radio"/> YES <input type="radio"/> NO	49. Was injury caused by injured's failure to use safety device? <input type="radio"/> YES <input type="radio"/> NO
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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 #
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56. Supervisor's Signature	57. Supervisor title
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58. Employee Signature	59. Date
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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/la 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?

<p>To be completed by Employer: Completado por el empleador:</p> <p>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 días.</p> <p>WORKER MUST INITIAL _____</p>	<p>Worker will choose health care provider. Yes__ No X Trabajador elegir proveedor de atención médica.</p> <p>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 días.</p> <p>INICIALES DEL TRABAJADOR</p>
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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 clínica / 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 días 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: (575) 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.

**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 NOTIFYING 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

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.

N/A

(Name of Physician)

N/A

(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

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 _____