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/injury to the employers designated workers' compensation benefit specialist- Samentha platero in personnel. Samentha, the workers' compensation benefit specialist, will then submit the information online and obtain the claim number.

All School sites must have a designated Worker's Compensation designee. Please provide Samentha Platero splatero@gmcs.org with the name of your school site Worker's Compensation designee.

READ THE FOLLOWING CAREFULLY – PLEASE NOTE, THE FORM MUST BE COMPLETED 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! The injured employee must notify their supervisor or worker's comp designee if at all possible before leaving the building. 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.

ALL WORK RELATED ACCIDENTS OR INJURIES MUST BE REPORTED TO THE DISTRICT

- **Injured employee must report injury to supervisor immediately**
- **Injured employee must complete the Notice of Accident form whether or not immediate medical attention is necessary**
- **Notice of Accident must be signed by both the injured employee and the Principal/Supervisor (or designee)**
- **Employers' first report of Accident form must be completed by the Administrator or work site designated Worker's Compensation person**
- **Use & Disclosure of health records form – must be filled out and signed by the employee**
- **The Employee must complete 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 along with pay options if out due to injury.)**
- **Report of Work Ability (ability to work)form must be taken to the hospital with the employee and completed by the attending medical personnel**
- **Supervisor's Accident Investigation Report must be completed by Principal**

Once the injured employee notifies his/her supervisor or Worker's Compensation designee of an accident or injury, GMCS must report the accident/injury to CCMSI within 72 hours of notification. See the condensed quote from Worker's Compensation Rule 11.4.3.13B.4 below:

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 selfinsurance 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/injury to the employer's designated Workers' Compensation benefit specialist – **Shauntiana Salazar in Personnel**. Shauntiana, 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,
Samentha Platero

Samentha Platero
Personnel Office
Worker's Comp - FMLA - OSHA
Telephone: (505)721-1186

GALLUP-McKINLEY
COUNTY SCHOOLS

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 by an occupational disease
Yo, (*name of employee/nombre del empleado*) *me lastimé en un accidente en el trabajo o fui incapacitado por enfermedad de oficio*

at approximately ______________, on ______________ 20___. Date of Hire _________ Employee's Date of Birth ____________
proximadamente (time/*a la(s) hora(s)*) *el* (date/*fecha*) (*del 20___.*) (*fecha de empleo*) (*fecha de nacimiento*)

Employee's social security number: ____________________ Employee's Home Address: ______________________________
Número de seguro social del empleado: *Direccion del empleado*

Employee's Telephone Number(s): Home: _______________ Mobile: _______________ Other: _______________
Número de teléfono(s): (*Casa*) (*Celular*) (*Otro*)

Where did the accident occur? ____
¿Dónde ocurrió el accidente?

What happened? ____
¿Qué ocurrió?
____
____

Worker will choose health care provider. Employer has right to change health care provider after 60 days.
Trabajador elegirá el proveedor de atención médica. El empleador tiene el derecho de cambiar el proveedor de atención médica después de 60 dias

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 (*Trabajador*)
For emergency medical care, go to any emergency medical facility. (*Para emergencias médicas vaya a cualquier clinica / hospital.*)

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.
(*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-WORKCOMP / 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-2- NMPSIA 2015

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): GMCS, PO Box 1318, Gallup, NM 87301, School:

PHONE NUMBER: 505-721-1061

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): 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: 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
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 formulario, póngase en contacto con un ombudsman (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 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

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 chooses to use any accrued sick leave for the first seven (7) calendar days of disability due to a Worker'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 average weekly rate or;

2. When accumulated leave is available Employee may elect to be paid 2/3 of average weekly wage through Worker's Comp and 1/3 of salary utilizing sick leave or other qualifying District leave benefits and retain full salary beginning on the 6th work day missed due to Worker's Compensation injury/illness.

All leave will run concurrently with FMLA

Initial next to applicable leave option. **If the employee fails to choose, you will be assigned Worker's Compensation pay.**

______ I understand I am requesting to go on Worker's Compensation Leave without Pay status because I have no accumulated leave. I understand that I will only receive payments from Worker's Compensation equal to 2/3 of my daily rate and my pay will be stopped until my physician releases me to return to work and if the District is unable to accommodate any restrictions or limitations due to the duties of my position.

______ I choose to utilize my accrued sick (or other qualifying) District leave at 1/3 of my daily/weekly rate in order to maintain full salary. I further understand I will be earning leave at 1/3 during the time I am out on Worker's Compensation.

______ I understand that CCMSI/WC will issue and mail checks directly to me. Any questions I may have will be directed to CCMSI Worker's Comp at 505-837-8700

______ If my disability due to a Worker's Compensation injury/illness exceeds 28 days, I agree to reimburse GMCS for any amount that is greater than 100% of my weekly gross wage due to use of District leave benefits and duplicated payment of Worker's Compensation benefits for the first seven (7) days of the disability.

____
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

REPORT OF WORK ABILITY

EMPLOYEE:	***1. PLEASE HAVE EACH HEALTHCARE CLINICIAN COMPLETE THIS FORM AT EACH VISIT TO THE CLINICIAN:*** ***2. PLEASE PROVIDE A COPY OF THE COMPLETED FORM TO YOUR SUPERVISOR AFTER EACH VISIT***
CLINICIAN:	***PLEASE COMPLETE, SIGN AND FAX THIS FORM TO EMPLOYMENT SERVICES AT:***

EMPLOYEE INFORMATION

Last Name ______________________________ First Name __________________________ Middle Initial____

Employee ID# ____________ Date of Birth ____________ Date of Injury/Illness ____________ Job Title/Description ________________ Phone ________________

Employer______________________________ Supervisor or Contact__________________ Employer Phone______________

Worker's Compensation Administrator/Billing Information **Claim Number** ______________________________
CCMSI, P.O. Box 30870, Albuquerque, NM 87190 505-837-8700

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.
Patient Signature:____ Date: ___________________________________

TREATING PROVIDER'S EVALUATION-COMPLETE IN FULL FOR EACH VISIT

Treatment Date______________________ For: ☐ Initial Treatment ☐ Follow-up Appointment

Nature of Visit: ☐ Work Related ☐ Not Work Related ☐ Unknown

Describe Circumstances of the Injury/Illness:____
Diagnosis:____
Treatment:____

Medication Prescribed Could Cause Drowsiness or Impair Ability and/or Operate Heavy Equipment: ☐ Yes ☐ No

Maximum Medical Improvement Reached: ☐ Yes ☐ No Date of MMI: ____________________
Impairment Rating (PPD) if applicable: ____
Referral/Consult: ____
Next Appointment: Date: ____________________ Time: __________________ Doctor: ________________________

EMPLOYEE CAPABILITIES

Employee is released from care and has no restrictions.

☐ **May return to work with no restrictions:** ☐ Immediately, or ☐ Beginning ____________________________

☐ Injury will result in loss of time from work: from ______________________ through ______________________

☐ May return to work with the following restrictions:____
from _____________ through _____________

☐ Estimated Return to Full Duty is: ____/____/____

TREATING PROVIDER

Provider Name (please print) ______________________________________ Clinic Name ____________________________

Provider Signature ____ Clinic Address __________________________

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

GENERAL INFORMATION

DEPARTMENT	SHIFT
EMPLOYEE NAME	JOB TITLE
EMPLOYEE NUMBER	SEX (M/F)

TYPE OF ACCIDENT/ILLNESS

TYPE OF INJURY

PART OF BODY INJURED	TREATMENT	DID EMPLOYEE RETURN TO WORK THE SAME DAY?
	☐ FIRST AID ☐ MEDICAL	☐ YES ☐ NO

DESCRIPTION

WHERE DID THE ACCIDENT HAPPEN? USE ADDITIONAL SHEETS IF NECESSARY

CAUSES

SPECIFIC MACHINE, TOOL, SUBSTATNCE OR OBJECT CONNECTED WITH THE ACCIDENT

UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIME OF ACCIDENT (Be Specific)

PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)

PERSONAL PROTECTIVE EQUIPMENT REQUIRED

WAS INJURED EMPLOYEE USING REQUIRED EQUIPMENT?

RECOMMENDATIONS

ACTION PLAN TO PREVENT RECURRENCE (Modification of Machine, Mechanical Guarding, Environment, Training)

SUPERVISOR'S SIGNATURE ______________________ DATE ______________

FOLLOW-UP

ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)