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 WORKSITE.
INCOMPLETE AND INCORRECT PACKETS/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 the injury to a 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
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/injury to the employer's 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.
If you have any questions or concerns, please email or call. I am constantly checking my email and responding faster via email.

Thank you.

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-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.

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

PHONE NUMBER 505-721-1186

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

NM WCA FORM E1.2 EQUIVALENT TO OSHA'S FORM 301 FORM IA-1 (7/02) © IAIABC 2002

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

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 ☐ FIRST AID ☐ MEDICAL	DID EMPLOYEE RETURN TO WORK THE SAME DAY? ☐ 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)

GALLUP-McKINLEY COUNTY SCHOOLS

EMPOWERING OUR FUTURE

K'Dawn Montano, Assistant Superintendent of Personnel
kmontano@gmcs.org

Director of Personnel
Jacob Stokes

Personnel Coordinator
Klo Abeita

LIMITED USE OF SICK LEAVE FOR A WORK RELATED INJURY

Lost Wages Benefits (indemnity payments) The Workers' Compensation Administration provides compensation benefits (calculated in accordance with state laws) to an employee for a portion of the time the employee is absent from the job due to work-related injury or illness.

The first seven (7) days (consecutive or nonconsecutive) of disability is considered to be the waiting period when no indemnity benefits are due, and must be charged to available Leave (Sick, Annual, or Without Pay). After the seven (7) day waiting period, the disabled employee will be entitled to Workers' Compensation indemnity benefits at an amount equal to 66% of the employee's average weekly wage or up to the statutory maximum allowed at the time of injury, **and will not be permitted to use Leave (Sick, Annual, or Without Pay).**

If the period of disablement extends past twenty-eight (28) days, Workers' Compensation will then pay the employee indemnity benefits for the first seven (7) days of the disablement. If this occurs and the employee used Sick or Annual Leave for the first seven (7) days, s/he is required to reimburse his/her Leave bank.

Payment of Insurance Premiums

When an employee is absent due to a work-related occurrence and is not receiving wages from GMCS, the employee must pay his/her portion of the premiums directly to GMCS. GMCS will continue payment of the matching premiums through the end of the current fiscal year or for as long as the employee continues to pay the premiums.

Family and Medical Leave Act (FMLA) FMLA benefits will run concurrently with employee's time off for a work related injury.

All leave will run concurrently with FMLA

Please read the following carefully and initial next to each line

_____ I choose to utilize my accrued sick (or other qualifying) District leave during the first seven (7) days of disability.

_____I further understand if the disability extends past seven (7) days and I am unable to resume work, my pay will be stopped to be restarted once I am released to return to work with no restrictions.

_____ 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

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 workplace 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 necesita 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

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 _____