WORKERS' COMPENSATION
INSTRUCTIONS AND FORMS PACKET – EMPLOYEES ONLY

Forms included in Packet:

1. Instructions
2. Notice of Accident or Occupational Disease Disablement
3. WC First Notice of Loss
4. Worker's Authorization for Use and Disclosure of Health Records
5. Employee Statement Regarding Cause of Accident & Request for Medical Treatment
6. WC Witness Report Form
7. WC Medical Providers
8. WorkMed/WC Treatment Authorization Form(2 separate forms)
9. WC Prescription Information
10. Return to Work Authorization Form

Instructions:

- If minor, obtain supplies from the first aid kit. First aid kits are located in the Sims Lab on the first floor, Gross Anatomy Lab and Student Copy Center in the Library on the second floor, and in the breakroom on the third floor. AED's are located on each floor across from the freight elevator.
- If more than first aid is needed, the employee should go to one of the urgent care providers listed on our Worker's Compensation Provider list. If medical provider is closed or for serious injuries that require hospital care, go directly to the emergency room at Memorial Medical Center, located at 2450 S. Telshore Blvd.
- The supervisor must secure the premises, eliminate hazards and investigate the cause of the accident.
- Supervisor will complete a WC First Notice of Loss form and call The Hartford at 1-800-327-3636 and submit to the Office of Human Resources within 24 hours. Office of Human Resources can assist with reporting claims during normal operating hours.
- Complete Notice of Accident or Occupational Disease Disablement Form and submit to the Office of Human Resources.
- Injured Employee completes Employee Statement Regarding Cause of Accident and Request for Medical Treatment.
- Any witness(s) will need to complete the Workers' Compensation Witness Report form.
- If employee requests medical treatment, supervisor completes the Worker's Compensation Treatment Authorization form and gives it to the injured employee.
- Employee completes Worker's Authorization for Use and Disclosure of Health Records.
- Complete Workers' Compensation Prescription Information form and give to injured employee.
- Provide employee with Return to Work Authorization Form so treating physician can complete it and give back to employee. Employee will need to return completed form to the Office of Human Resources.
- Return completed forms to the Office of Human Resources (Reminder: Give the WC Treatment Authorization & Prescription Information to Injured Employee).

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 **Employer/employee: Each keep one copy.** **Empleador/empleado: Retener una copia.** **----SEE BACK OF THIS FORM----** **----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

Workers' Compensation First Notice of Loss

THE HARTFORD

Telephonic Reporting: 1-800-327-3636
Fax Reporting: 1-800-347-8197
E-mail Reporting: lossconnect@thehartford.com

Please complete the following comprehensive list of questions to report your Workers' Compensation Loss. You can use this template for phone, fax or e-mail submission. Asterisks (*) denote information that is critical to proper handling office assignment. Please be sure to obtain this information prior to reporting a claim.

EMPLOYER / LOSS LOCATION INFORMATION

Policy Number: 34WE AD0KV9 Account Number: _____ IRC / Loc. Code: _____
*Filing State: New Mexico *Date of Loss: _____ Time of loss: _____
Account Name: Burrell College of Osteopathic Medicine Employer Name: Burrell College of Osteopathic Medicine
Address: 3501 Arrowhead Dr.
City: Las Cruces State: New Mexico Zip Code: 88001
Business Phone: (575)674-2284 or (575)674-2370(Office of HR) (575)674-2266 (Main Line)
Mailing Address: 3501 Arrowhead Dr.
City: Las Cruces State: New Mexico Zip Code: 88001
Accident Location Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Did the injury occur on the insured's premises? ☐Yes ☐ No If no, where did injury occur? _____

PERSON REPORTING CLAIM TO THE HARTFORD – INFORMATION

Name: _____ Title: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Mobile Phone: _____ Fax Number: _____
Email Address: _____

INSURED CONTACT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Mobile Phone: _____ Fax Number: _____
Email Address: _____ Contact Preference: ☐ Email ☐ Mail ☐ Phone

EMPLOYEE/CLAIMANT INFORMATION

Employee Name: _____
Employee Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____ Mobile Phone: _____

Email Address: _____

Social Security Number: _____ Date of Birth: _____ # of Dependents: _____

Gender: _____ Marital Status: _____ Preferred Language: _____

EMPLOYMENT INFORMATION

Date of Hire: _____ State of Hire: _____ Date Shift Begin: _____

Time Shift Begin: _____ ☐ AM ☐PM Time Shift Ends: _____ ☐ AM ☐PM

Hours Worked Per Day: _____ Days Worked Per Week: _____

Pay Type: ☐ Hourly ☐ Weekly ☐ Monthly ☐ Salary

Pay Check Frequency: ☐ Bi Weekly ☐ Weekly ☐ Monthly ☐ Twice Monthly

Is the claimant's typical work schedule Monday through Friday? ☐ Yes ☐ No ☐ Unknown

Is it a fixed or varied schedule? ☐ Fixed ☐ Varied ☐ Unknown

Scheduled Work Days: ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Employment Status: ☐ Full Time ☐ Part Time ☐ Seasonal/Temporary ☐ Other/Unknown

Recent Disciplinary Action: ☐ Yes ☐ No ☐ Unknown

Occupation: _____ Regular Department: _____

Injured in Regular Occupation? ☐ Yes ☐ No ☐ Unknown

Department Where Injury Occurred: _____

Describe Physical Demands of the Employee's Job:

☐ Sedentary (sitting most of the time)
☐ Light (usually walking or standing)
☐ Medium (exerting up to 10lbs of force constantly)
☐ Heavy (exerting up to 20lbs of force constantly)
☐ Very Heavy (exerting excess 20lbs of force constantly)
☐ Unknown

NCCI (Job Class Code): _____ Officer/Owner/Partner? ☐ Yes ☐ No ☐ Unknown

Supervisor Name: _____

Supervisor Address: _____

City: _____ State: _____ Zip Code: _____

Supervisor Day Phone: _____ Supervisor Mobile Phone: _____

Supervisor Email Address: _____

LOSS INFORMATION

*Please provide a description of the accident (what was employee doing at time of injury and what type of injury was sustained):

Injury Result in Death? ☐ Yes ☐ No

Was the employee injured while performing normal job duties? ☐ Yes ☐ No ☐ Unknown

Did the injury occur during normal work hours? ☐ Yes ☐ No ☐ Unknown

Do you question the injury? (If yes, provide Reason in Additional Information below) ☐ Yes ☐ No ☐ Unknown

Date of Notice (Reported to Employer): _____ Time Reported: _____

Who was the injury reported to? _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Mobile Phone: _____

Email Address: _____

Does the employee have Group Health Insurance? ☐ Yes ☐ No ☐ Unknown

Name of Group Health Carrier: _____

Address: _____

City: _____ State: _____ Zip Code: _____
Phone: _____ Has the employee received treatment? ☐ Yes ☐ No ☐ Unknown

INITIAL TREATMENT INFORMATION

Incident only: ☐ Yes ☐ No ☐ Unknown

Where did employee receive treatment?
☐ Clinic ☐ Emergency Room ☐ First Aid ☐ Other ☐ Admitted to Hospital ☐ Unknown

Emergency transportation required? ☐ Ambulance ☐ Helicopter ☐ Other _____
Medical Provider Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Business Phone: _____ Name of Physician: _____
Treatment Type: ☐ Stitches ☐ X-ray ☐ Physical Therapy ☐ Other: _____
Additional Treatment Received: _____
Do you expect further medical treatment? ☐ Yes ☐ No ☐ Unknown
If Yes: Will the injury require surgery? ☐ Yes ☐ No ☐ Unknown

LOST TIME

Has the employee lost time from work? ☐ Yes ☐ No ☐ Unknown

IF YES

Last Date Worked: _____ First Day Missed: _____
Salary/Wages Continued: ☐ Yes ☐ No ☐ Unknown

Paid for Date of Injury? ☐ Yes ☐ No ☐ Unknown
*Has the employee returned to work? ☐Yes ☐No ☐ Unknown
Date returned or expected to return to work: _____
Will or has the employee returned to: ☐ Regular Duty ☐ Light Duty ☐ Unknown
Will or has the employee returned to reduced hours or wage? ☐ Yes ☐ No ☐ Unknown
Is there any intermittent lost time? ☐ Yes ☐ No ☐ Unknown

ADDITIONAL INCIDENT INFORMATION

Was the employee performing an unsafe act? ☐ Yes ☐ No ☐ Unknown
Did the injury involve equipment or machinery? ☐ Yes ☐ No ☐ Unknown
If Yes: Was the equipment or machinery defective? ☐ Yes ☐ No ☐ Unknown
Safety equipment provided? ☐ Yes ☐ No ☐ Unknown
Safety equipment used? ☐ Yes ☐ No ☐ Unknown

Is a 3rd party potentially responsible for the injury? ☐ Yes ☐ No ☐ Unknown

IF YES

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Night Phone: _____
Mobile Phone: _____ Email Address: _____

Are there any witnesses? ☐ Yes ☐ No ☐ Unknown

IF YES

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Night Phone: _____

Mobile Phone: _____ Email Address: _____

Has the employee had previous injuries? ☐ Yes ☐ No ☐ Unknown

IF YES:

Please describe:

ADDITIONAL INFORMATION

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.

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

Revised 10/1/15

EMPLOYEE STATEMENT REGARDING CAUSE OF ACCIDENT
AND
REQUEST FOR MEDICAL TREATMENT

Employee Name: _____ SSN: _____

Date of Birth _____ Date of Injury: _____

Job Title: _____ Supervisor's Name_____

Telephone contact Information: _____ Supervisor's Signature: _____

Dept. /Center: _____ Supervisor's telephone #: _____

Employee Refused Medical Care at time of Injury □Yes □No

List activity prior to accident (work related activity only):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Employee Signature Date

Workers' Compensation Witness Report Form

Name of Injured Employee: _____

Name of Witness: _____

Telephone # of Witness_____

Location where Incident Occurred: _____

Date of Incident: _____ Time of Incident: _____

1. What were you (the witness) doing at the time of the incident?

_____

2. How and when did you become aware of the incident?

_____

3. What did you hear at the time of the incident?

_____

4. Describe what you saw at the time of the incident:

_____

5. Who else was present?

_____

6. Please relate any additional information you have pertaining to the incident:

_____
_____
_____
_____
_____

Witness Signature: _____ Date Signed: _____

WORKER'S COMPENSATION
MEDICAL PROVIDERS

WorkMed Occupational Health
2525 S. Telshor, Suite 16-108
Las Cruces, NM 88011
Ph: (575) 521-1919
Fax: (575) 521-1676

Hours: Monday –Friday
8:00 a.m. – 5:00 p.m.
No Appointments Necessary
Walk-Ins Encouraged

FOR LIFE THREATENING SITUATIONS-Call 911 or go to the closest emergency room

Memorial Medical Center
2450 S. Telshor Blvd.
Las Cruces, NM 88011

Mountain View Regional Medical Center
4311 E. Lohman Ave
Las Cruces, NM 88011

FOR NON-EMERGENCY AFTER HOUR CARE

Mountain View Urgent Care
1455 S. Valley Dr. Ste. A
Las Cruces, NM 88005
9:00 am-8:00 pm

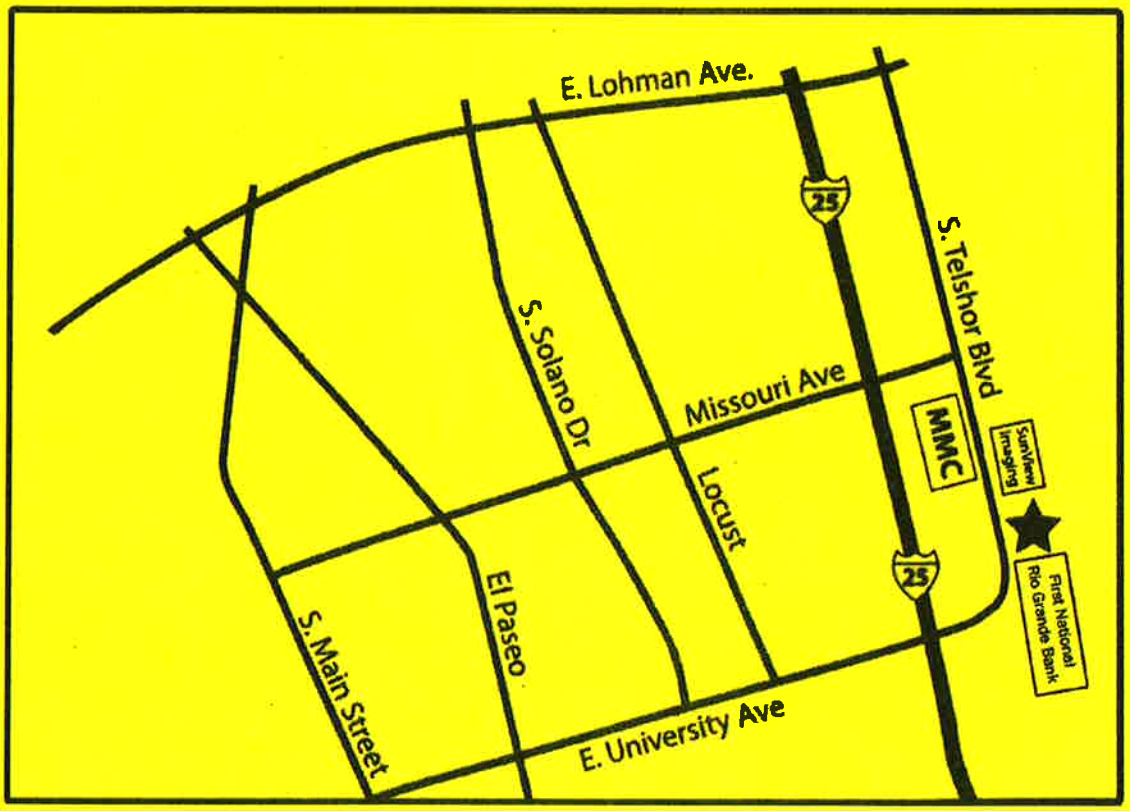
Memorial Urgent Care
4672 Sonoma Ranch Blvd.
Las Cruces, NM 88011
8:00 am-11:00pm

WorkMed

Occupational Health

2525 S. Telshor, Suite 16-108 • Las Cruces, NM 88011
Ph: (575) 521-1919 • Fax: (575) 521-1676

Monday-Friday
8:00 a.m. - 5:00 p.m.
No Appointments Necessary
Walk-Ins Encouraged



☐ **Work Related Injury/Illness**

☐ **Modified Work/Light Duty for this Employee is:** ☐ **Available** ☐ **Not Available**

Special Instructions: _____

Authorized By: _____ **Date:** _____

Appointment Date: _____ **Time:** _____

WORKERS' COMPENSATION TREATMENT AUTHORIZATION FORM

This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Policy Number: 34 WE AD0KV9

Employer Name: Burrell College of Osteopathic Medicine

Employer Address: 3501 Arrowhead Drive, Las Cruces, New Mexico 88001

Employee Name: _____

Social Security Number: _____ Date of Injury: _____

Type of Injury: _____

Body Part Injured: _____

Signature of Supervisor issuing form: _____

Supervisors: Please give this completed form to the injured employee to take with them to Medical Provider.

This form is for **one-time** use, only on this date _____.

Providers: You must call The Hartford toll free at 1-877-853-2582 prior to any additional treatment/admission or referral, other than an emergency. In an emergency, notification to The Hartford is required within 24 hours.

SEND MEDICAL BILLS TO:

The Hartford

P.O. Box 14170

Lexington, KY 40512

Phone: (877) 853-2582

GIVE TO INJURED EMPLOYEE

Workers' Compensation Prescription Information

Supervisor: Please fill out the employee information below and provide employee with this document. The employee will need to call **Express Script at 1(888) 289-1407** to fill prescriptions for WC injury.

Employee Name:	
Policy #:	34 WE AD0KV9
Employee SSN:	
Date of Injury:	

Supervisor's Signature: _____

Phone: _____

Date: _____

Return to Work Authorization Form

Employee's Name: _____

Was Seen On: _____

For: ___ Office Visit ___ Injury Treatment ___ Follow-up Other: _____

Next Appt.: _____
(If applicable)

Recommendation: _____ May Not Work _____ May return to work on: _____
(mm/dd/yyyy)

If employee may return to work, please specify:

_____ Return to work at Full-Duty (No Restrictions)

_____ Return to work at Modified Duty with the following restrictions:

_____ Hours per day

_____ Light duty: (Please explain what employee may/may not do below)

_____
_____
_____

Other: (please specify)

_____
_____
_____

_____ _____ _____
(Print) Name of Health Care Provider Signature Date

_____ _____
(Print) Name & Type of Practice Phone number (w/area code)

BURRELL COLLEGE OF OSTEOPATHIC MEDICINE - Human Resources Dept. @ ph.: (575) 674-2284

GIVE FORM TO EMPLOYEE