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. Telshor 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 Travelers at 1-800-238-6225 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

TRAVELERS

Workers Compensation Claim Reporting Worksheet and Guide

We will produce and submit the necessary state forms and filings.

! **DO NOT DELAY IN REPORTING IF YOU DO NOT HAVE ANSWERS TO ALL THE QUESTIONS.**
PLEASE EMAIL YOUR COMPLETED FORM TO first.report@travelers.com OR CALL 1.800.238.6225.

ACCOUNT / ACCIDENT INFORMATION

PREPARER'S PHONE NUMBER	PREPARER'S TITLE	PREPARER'S NAME	EMPLOYMENT STATE

SUBSIDIARY (COMPANY) NAME	SUBSIDIARY (COMPANY) ADDRESS (STREET, CITY, STATE & ZIP)	SUBSIDIARY (COMPANY) MAILING ADDRESS (STREET, CITY, STATE & ZIP)
N/A	N/A	☐ SAME N/A

DID THE ACCIDENT OCCUR AT THE LOCATION ADDRESS?
☐ YES ☐ NO IF NO, ADDRESS WHERE ACCIDENT OCCURRED

PARENT COMPANY / INSURED'S NAME
Burrell College of Osteopathic Medicine

LOCATION CODE	POLICY SYMBOL AND NUMBER	NATURE OF BUSINESS
	UB-B0300847-25-14-G	Higher Education (Osteopathic Medical School)

DATE OF INJURY	TIME OF INJURY

ACCIDENT DESCRIPTION

EMPLOYEE INFORMATION

INJURED EMPLOYEE'S SOCIAL SECURITY NUMBER:	EMPLOYEE'S NAME (FIRST, MI, LAST)	GENDER ☐ MALE ☐ FEMALE	PRIMARY LANGUAGE

DATE OF BIRTH	EMPLOYEE'S MAILING ADDRESS

EMPLOYEE'S PHONE NUMBER	EMPLOYEE'S HOME ADDRESS (IF DIFFERENT FROM MAILING)	EMPLOYEE'S EMAIL ADDRESS

EMPLOYEE JOB INFORMATION

EMPLOYMENT STATUS CODE ☐ FULL-TIME ☐ PART-TIME ☐ OTHER	REGULAR ASSIGNED DEPARTMENT	REGULAR OCCUPATION
OCCUPATION WHEN INJURED		
EMPLOYEE'S WORK SCHEDULE REGULAR WORK HOURS _____	HOURS/DAY _____	DAYS/WEEK _____
EMPLOYEE'S WAGE INFORMATION: $_____HOUR OR $ _____/ ANNUAL OR_____/ WEEKLY OVERTIME: $_____ ADD'L BENEFITS: $_____		
DATE OF HIRE OR LENGTH OF EMPLOYMENT		

SUPERVISOR'S NAME:	SUPERVISOR'S PHONE NUMBER:	SUPERVISOR'S EMAIL ADDRESS:	BEST HOURS TO CONTACT

ACCIDENT INFORMATION

DATE CLAIM REPORTED TO EMPLOYER?	DID EMPLOYEE LOSE ANY TIME FROM WORK OR ARE THEY WORKING MODIFIED DUTY BEYOND THE DATE OF THE INJURY? ☐ YES ☐ NO	IS THE EMPLOYEE BACK AT WORK? ☐ YES ☐ NO IF YES, DATE RETURNED TO WORK? IS THERE AN ANTICIPATED RETURN TO WORK DATE? ☐ YES ☐ NO IF YES, ANTICIPATED RETURN DATE?

RETURN TO WORK STATUS ☐ LIGHT ☐ MODIFIED ☐ REGULAR	DATE EMPLOYEE LAST WORKED	WAS INJURY FATAL? IF YES, DATE OF DEATH ☐ YES ☐ NO
DO YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE INJURY? ☐ YES ☐ NO	IF YES, WHAT ARE YOU QUESTIONING? ☐ INJURY WORK RELATED ☐ EXTENT OF INJURY ☐ OTHER	

WITNESS INFORMATION

NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	
NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	
NAME (FIRST, MI, LAST)	PHONE NUMBER
ADDRESS	

INJURY INFORMATION

CAUSE OF ACCIDENT (E.G., SLIP/FALL, LIFTING, CHEMICAL)

PART OF BODY INJURED (E.G., HEAD, NECK, ARM, LEG)

NATURE OF INJURY (E.G., FRACTURE, SPRAIN, LACERATION)

PRIOR INJURY OR PRE-EXISTING CONDITION(S) (IF YES, PLEASE DESCRIBE)
☐ YES ☐ NO

TREATMENT ("X" ALL THAT APPLY)

☐ UNKNOWN
☐ NO MEDICAL TREATMENT
☐ FIRST AID/MINOR ON SITE TREATEMENT
☐ DOCTOR'S OFFICE/WALK-IN CLINIC
☐ EMERGENCY ROOM
☐ HOSPITAL/CLINIC – ADMITTED >24 HOURS

DESCRIPTION OF TREATMENT AND DATE OF 1st TREATMENT

NAME, ADDRESS, PHONE NUMBER OF TREATING FACILITY

PHYSICIAN NAME

INSURED CONTACT INFORMATION

CONTACT NAME	PHONE NUMBER
EMAIL ADDRESS	BEST TIME TO CONTACT AND WHERE TO CONTACT

ADDITIONAL NOTES/COMMENTS OR CUSTOMER SPECIFIC INFORMATION

TRAVELERS

travelers.com

CE-10347 New 12-17

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

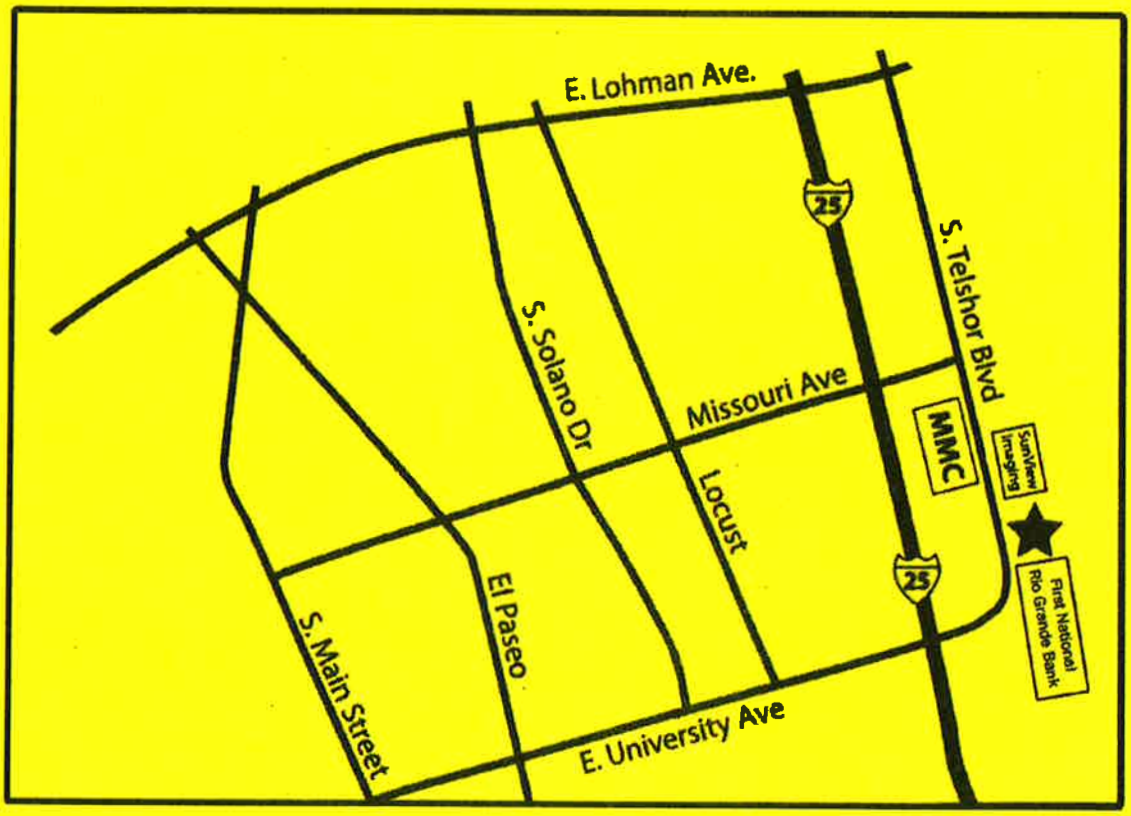
Memorial Urgent Care
4672 Sonoma Ranch Blvd.
Las Cruces, NM 88011
8:00 am-11:00pm

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: UB-B0300847-25-14-G

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 Travelers toll free at 1-800-238-6225 prior to any additional treatment/admission or referral, other than an emergency. In an emergency, notification to The Travelers is required within 24 hours.

SEND MEDICAL BILLS

TO: The Travelers

P.O. Box 660456

Dallas, TX 75266

Phone: (800) 238-6225

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 **Healthesystems at 1(877) 528-9497** to fill prescriptions for WC injury.

Employee Name:	
Policy #:	UB-B0300847-25-14-G
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