LAS CRUCES PUBLIC SCHOOLS

WORKERS' COMPENSATION PROCEDURES & GENERAL INFORMATION PACKET

PLEASE SUBMIT TO:

LCPS Department of Public Safety
3600 Arrowhead Dr. BLDG 7
LAS CRUCES, NM 88011
575-527-5810

In order to be eligible for Workers' Compensation benefits for work-related injuries or occupational illnesses, employees must adhere to the following Workers' Compensation Procedures.

— **Report injury or illness to LCPS Public Safety Department and Supervisor, Principal, or Nurse IMMEDIATELY.** Report can be made via phone call, email, and/or Las Cruces Public Schools Accident/Exposure Report (attached; page 3)
  - Reporting injury/illness to a coworker is not considered proper notice
  - The Workers' Compensation Act requires a worker to report every accident to their supervisor within 15 days of occurrence. NMPSIA requests that all work-place injury/illnesses are reported within 24 hours and no later than 72 hours after injury/illness.

— **Submit Notice of Accident or Occupational Disease Disablement** (attached; page 4) to LCPS Public Safety Department as soon as possible.

— **Submit NMWCA Employer's First Report of Injury or Illness** (attached; pages 5-6) to LCPS Public Safety Department as soon as possible.

— **Provide the name of the physician, if any, who will be providing care for work-related injury/illness.**
  - **Las Cruces Public Schools does NOT direct medical care involving Workers' Compensation claims.** Employees are allowed to seek medical care from a physician of their choosing.
  - The health care provider must accept Workers' Compensation Insurance. It is the employee's responsibility to verify before continuing care.

- Las Cruces Public Schools and CCMSI retain the right to change health care provider after 60 days, if they feel it is necessary.

— **Submit NMWCA Worker's Authorization for Use & Disclosure of Health Records** (attached; page 7)

— **Employee must provide copies of any and all physician documentation, including work restrictions, to LCPS Department of Public Safety.**

- Employees are responsible for following health care provider's medical instructions/ restrictions
  - Return-To-Work restrictions must be processed and approved by the LCPS Department of Public Safety before employee can return to work.
  - If necessary, a Modified Job Duty Offer must be signed before employee can return to work.

Other Important Information:

- All documentation will be submitted to CCMSI, our third party administrator for Workers' Compensation, where claim acceptance or denial will be decided after review.
- If employee misses work because of a work-related injury/illness, Workers' Compensation will provide indemnity pay at a rate of 66 2/3% of employee's regular pay based on a 29-week wage history, after the 7th calendar day of lost time.
  - After the 28th day of lost work, employee be paid for the first 7 days.
  - In the event that the employee is out of work for more than 7 days, all leave (sick, personal, and annual) will be used to continue your pay from LCPS at 100%.
    - If employee is out of work for more than 7 days and all leave has been exhausted, employee will receive Workers' Compensation checks at 66 2/3% of normal salary. Checks will be mailed to LCPS Department of Public Safety and employee will be called to pick them up.
    - If employee is out of work for more than 7 days and all leave has not been exhausted, Workers' Compensation checks will be mailed to LCPS Department of Public Safety and employee will be required to sign over check to LCPS.
- For absences that extend past 5 days, employee must contact the LCPS Human Resources Department to submit a request for Family Medical Leave.

Employee (Please print): _____ Date: _____

Employee Signature: _____

LCPS Department of Public Safety: _____ Date: _____

Las Cruces Public Schools, District No. 2
Accident/Exposure Report

Who was injured: ( ) Employee ( ) Parent ( ) Visitor ( ) Volunteer School_____

1. Name:_____
2. Address:_____City:_____Phone:_____
3. DOB:_____Sex:_____Job Title:_____
4. Date/Time of Accident/Exposure:_____
5. Description of Accident/Exposure:_____
   _____
   _____
6. Body fluid contact: ( ) NO ( ) YES What body fluid:_____
7. Was personal protective equipment used at time of exposure: ( ) NO ( ) YES
8. Type of equipment utilized:_____
9. Parts of body involved:_____
   _____
10. Description of action taken by school personnel immediately following injury:_____
    _____
    _____
11. Nursing comments:_____
    _____
    _____

    Nurse Signature: _____Date:_____
12. Was injured person taken to doctor/hospital? ( ) NO ( ) YES Name:_____
13. Referred for post-exposure evaluation and Follow up? ( ) NO ( ) YES
14. Witness to Accident /Exposure:

    Name: _____ Address: _____Position:_____
15. Person completing report:_____
    Name Title

Revised 3/2015

RESET FORM

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 días

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 clínica / 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 ("ombudsmen") 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 – *Línea 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) 566-7310
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(888)311-8587
Santa Fe: (505) 476-7381
TDD for the deaf: (505) 841-6043
www.workerscomp.state.nm.us

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)

PHONE NUMBER | 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

CARRIER (NAME, ADDRESS & PHONE NO)
NMPSIA
410 Old Taos Hwy.
Santa Fe, NM 8750)

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
850345437

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

ADDRESS (INCL ZIP)

PHONE NUMBER

GENDER
☐ MALE
☐ FEMALE
☐ UNKNOWN

MARITAL STATUS
☐ UNMARRIED SINGLE/DIVORCED
☐ MARRIED
☐ SEPARATED
☐ UNKNOWN

OF DEPENDENTS

OCCUPATION/JOB TITLE OR (SOC) CODE

EMPLOYMENT STATUS

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.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

Phone: (505) 841-6000 — In-State Toll Free: 1-800-255-7965

FARMINGTON: 599-9746/1-800-566-7310 — LAS CRUCES: 524-6246/1-800-870-6826

LAS VEGAS: 454-9251/1-800-281-7869 — LOVINGTON: 396-3437/1-800-934-2450

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, and must be completed by the employer or the employer's representative.

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. It must be filed even if the employer disputes the worker's claim of work-related injury or illness.

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. Copies must also be provided to the worker and the employer's workers' compensation insurer.

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to $1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication *Guide to Completing the Employer's First Report of Injury or Illness*, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits.*

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).

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 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

Rev. 10/17
11.4.4.9 NMAC

INJURY REPORTING PROCESS