

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/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: Dirección 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: _____
Firma: (employee/empleado)

Signed/Notice Received: _____
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 ("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 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) 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.**

WORKER'S AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)

I, (Print Worker's Name) _____, hereby authorize the health care provider (HCP) – (the name of HCP is optional and not required for release of medical information) (Print Health Care Provider's Name) _____ the use or disclosure of my health information as described in this authorization.

1. INFORMATION

WCA No. _____

Date of Birth _____ Date of Injury _____ SSN _____

Address _____ Phone _____

Worker's representative, if any: _____ Phone _____

Address: _____

2. RELEASE

I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer, _____, and/or its insurance carrier, _____, and/or their attorneys, and/or duly authorized representatives of the New Mexico Workers' Compensation Administration and its current medical cost containment contractor or their duly authorized agents. Copies of all documentation released pursuant to this authorization shall be sent to the agency requesting the information and to me or my representative as listed above.

3. I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: medical reports; clinical notes; nurses' notes; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. This Authorization also includes, if applicable, any hospital operational logs, emergency logs, tissues committee reports, psychiatric reports and records, physical therapy records, and all outpatient records. This release may also be used to request a Form Letter to HCP as approved by the Workers' Compensation Administration. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

CONDITIONS

4. I understand the purpose of this request is to determine the proper level of workers' compensation benefits and may include information regarding any of the following: to determine my occupational injury or illness status; to determine my eligibility for workers' compensation benefits; to determine my current and future medical status after occupational injury; to determine my current medical status and/or return-to-work capability.

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying the company named in Paragraphs 1 and 2. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive occupational injury or workers' compensation benefits governed by this revocation.

6. I understand that after this information is disclosed, the recipient may continue to use it pursuant to my prior authorization, regardless of my subsequent revocation of this authorization. I further understand that different protections may be available pursuant to state and federal law.

To be completed by Employee and Signed and dated

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization Yes No - If Yes, I have received a copy _____ (initial)
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee _____ Date _____

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): _____

Signature of Personal Representative _____ Date _____

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) CLOVIS MUNICIPAL SCHOOLS P.O. BOX 19000 CLOVIS, NM 88102-9000		CARRIER / ADMINISTRATOR CLAIM #	OSHA LOG NUMBER	REPORT PURPOSE CODE			
	PHONE NUMBER (575)769-4327		EMPLOYER FEIN 856000118	JURISDICTION	JURISDICTION CLAIM NUMBER			
	INSURED REPORT NUMBER		EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)					
	LOCATION #		INDUSTRY CODE					
CLAIMS ADMINISTRATOR	CARRIER (NAME, ADDRESS & PHONE NO) NMPSIA 410 Old Taos Hwy, Santa Fe, NM 87501		POLICY PERIOD TO	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		<input checked="" type="checkbox"/> CHECK IF APPROPRIATE SELF INSURANCE					
EMPLOYEE	NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE		
	ADDRESS (INCL ZIP)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN	OCCUPATION/JOB TITLE OR (SOC) CODE			
	PHONE NUMBER		# OF DEPENDENTS		EMPLOYMENT STATUS			
					NCCI CLASS CODE			
WAGE	RATE	PER:	<input type="checkbox"/> DAY <input type="checkbox"/> WEEK	<input type="checkbox"/> MONTH <input type="checkbox"/> OTHER:	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
						DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
OCCURRENCE	TIME EMPLOYEE BEGAN WORK	<input type="checkbox"/> AM <input type="checkbox"/> PM	DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE	<input type="checkbox"/> AM <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO			
TREATMENT	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS)			HOSPITAL (NAME & ADDRESS)			INITIAL TREATMENT	
							<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL/ LOST TIME ANTICIPATED	
OTHER	WITNESSES (NAME & PHONE #)							
	DATE ADMINISTRATOR NOTIFIED		DATE PREPARED	PREPARER'S NAME & TITLE				