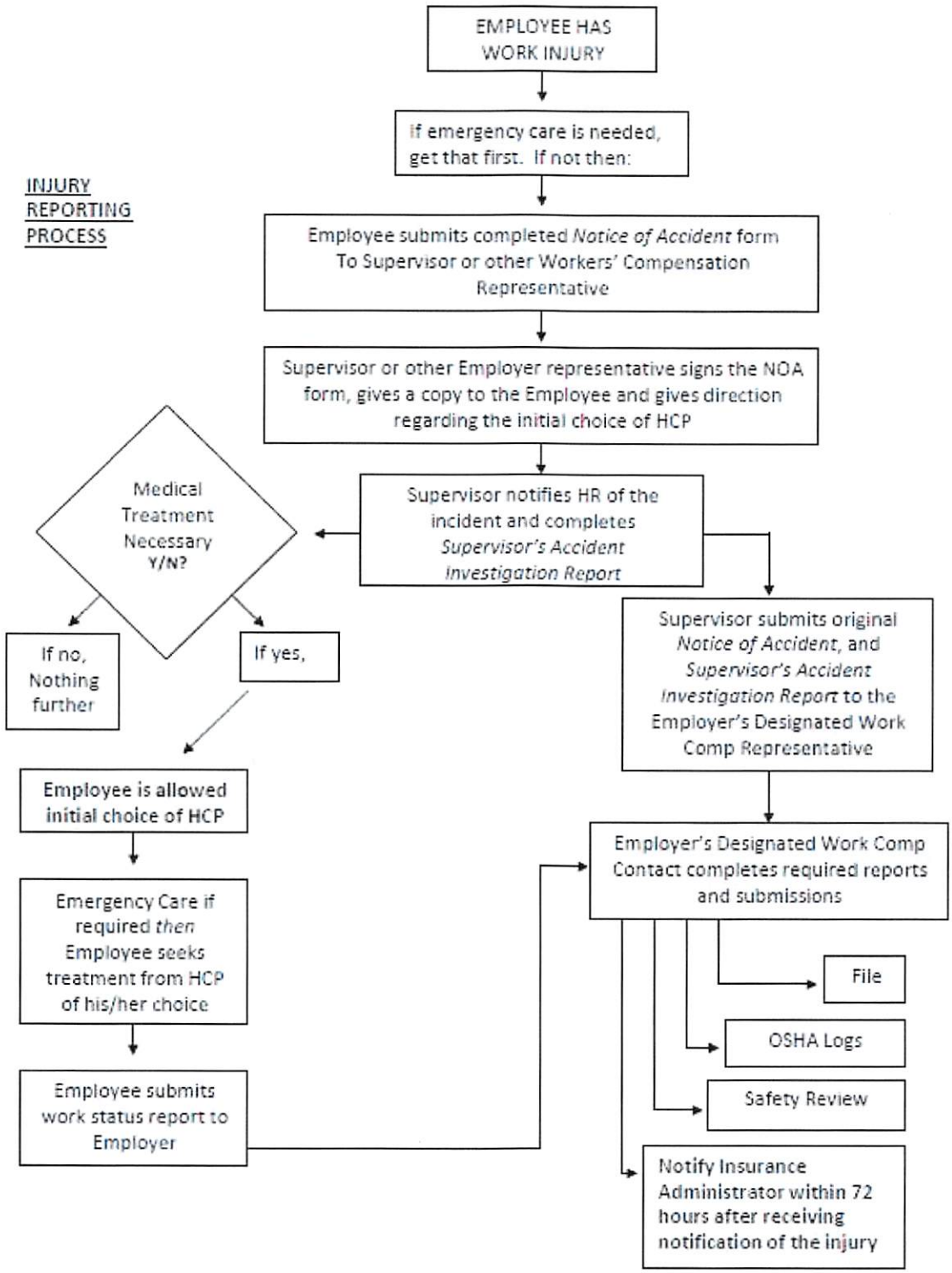
# BERNALILLO PUBLIC SCHOOLS

## Worker Injury Supervisor Flowchart




*Updated 2/26/2019*

# 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:**
*Completado por el empleador:*

**If Yes, Employer has 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.*

Worker will choose health care provider. Yes ✓ No___
*Trabajador elegirá proveedor de atención médica.*

**If No, Worker has the right to change health care provider after 60 days.**
*En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.*

**WORKER MUST INITIAL ____ *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

**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
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.*

Form NOA-1-W (4/12)

# 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 / CLAIMS ADMIN**

CARRIER ( NAME, ADDRESS & PHONE NO )

CARRIER FEIN | POLICY / SELF-INSURED NUMBER | ADMINISTRATOR FEIN

AGENT NAME & CODE NUMBER

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**

ADMINISTRATOR FEIN **841094892**

**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.

Administrator signs _____ Date _____

# Bernalillo Public Schools Supervisor Investigation Form

(To be submitted to Human Resources within 24 hours of notification of a workplace injury)

**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<br>☐ FIRST AID ☐ MEDICAL | DID EMPLOYEE RETURN TO WORK THE SAME DAY?<br>☐ 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)

*Revised 2/1/2019*