NEW MEXICO PUBLIC SCHOOLS INSURANCE AUTHORITY

WORKERS' COMPENSATION
PROPERTY & LIABILITY CLAIMS

WORKBOOK

Cannon Cochran Management Services, Inc.
PO Box 30870 ● Albuquerque, NM 87190-0870
800-635-0679 ● 505-837-8700 ● Fax: 505-888-6794 ● www.ccmsi.com

This workbook is provided as a reference for claim reporting procedures by Cannon Cochran Management Services, Inc. on behalf of New Mexico Public School Insurance Authority.

Workers' compensation reporting requirements are established by the state of New Mexico.

NMPSIA is a self-insured government pool in which all members share in the risk and rewards of prudent claim prevention and claim management.

Claims reported by NMPSIA Members are managed by CCMSI on a team approach that utilizes input and communication between NMPSIA, the NMPSIA Insured Member, and CCMSI Claims Representatives until the resolution of the claim.

IF YOU HAVE ANY QUESTIONS REGARDING THIS WORKBOOK OR ABOUT REPORTING A CLAIM, PLEASE CONTACT YOUR CLAIM REPRESENTATIVE OR THEIR SUPERIVSOR

Cannon Cochran Management Services, Inc.
www.ccmsi.com
4300 San Mateo NE, Suite A-300
Post Office Box 30870
Albuquerque, New Mexico 87190-0870

505-837-8700
800-635-0679

Workers' Compensation Fax: 505-888-6794

Property and Liability Fax: 505-888-6901

FORMS IN THIS WORKBOOK CAN BE FOUND AT
NMPSIA.COM

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SECTION 1

WORKERS COMPENSATION CLAIMS REPORTING REQUIREMENTS

INFORMATION YOU NEED TO KNOW

Cannon Cochran Management Services Inc. (CCMSI) manages all NMPSIA's workers' compensation claims. Inquiries on claims should be directed to them at 505-837-8700 or 1-800-635-0679.

The New Mexico Workers'* Compensation *Administration (WCA) regulates all group self-insured funds in New Mexico. They mediate contested claims as well as levy fines for noncompliance. They also have an ombudsman program for employers and employees alike. Their mailing address and phone number is:

Workers' Compensation Administration
PO Box 27198
Albuquerque, NM 87125-7198
1-800-255-7965 or 841-6000

E 1.2 Employer's First Report of Injury or Illness Form **-** used to report all on-the-job injuries. NMPSIA requests that all injury/illnesses be reported to CCMSI within 24 hours of the injury/illness or within 24 hours of your first knowledge of the accident/injury, but no later than 72 hours. The First Report can be entered online using ICE (Internet Claims Edge).

PLEASE NOTE: Employers who report injuries late are subject of up to $1,000 by the Workers' Compensation Administration. Because late reporting also seriously obstructs any investigation CCMSI may need to conduct, NMPSIA has also instituted an assessment of $100.00 for each First Report of Injury that is 1-30 days late and a $500.00 assessment if the First Report is more than 30 days late.

Notice of Medical Provider. You must post **in writing** your choice of medical provider in your area or post a notice in writing that the injured employee can make the initial choice of medical provider. If you do not post either of these notices, an employee may choose the doctor they prefer and **you may never be able to petition for** a **change of provider.** This makes the claim more difficult to manage and can also increase your workers' compensation costs.

Correspondence From the Workers' Compensation Administration (WCA).
If you receive *any petitions or claims from the WCA, please notify* CCMSI *immediately. Very stringent time* frames *are involved and failure to act immediately could result in serious legal consequences.*

Employer Involvement. NMPSIA & CCMSI encourages you to become involved with your claims. Good communication between the employer, the injured worker, and CCMSI Claim Personnel is essential in controlling the cost of the claim. Please advise your employees to cooperate with them. **DO NOT** advise them to seek an attorney.

Modified Duty. Modified duty is legitimate work that an injured worker can perform until the health care provider has given the injured worker a full work release. It cannot be "made-up-work" and should have a time limit (for example, 12 weeks, the same period as FMLA).

What Do I Do When? There is an On-The-Job Injury

EMERGENCY

1) If it is an emergent situation, take the employee to the nearest emergency room or call 911.
2) Fill out the ICE report online within 24 hours (72 hours at the latest).
3) CCMSI contact information is:

Cannon Cochran Management Services Inc.
P.O. Box 30870
Albuquerque, NM 87190-0870
Telephone: 505-837-8700 / Fax: 505-888-6794
www.ccmsi.com

NON-EMERGENCY

(INJURIES REQUIRING MEDICAL CARE)

1) Take or direct, depending on your policy, the Injured Worker to the designated Medical Provider.
2) Fill out the ICE report online within 24 hours (72 hours at the latest).

PLEASE NOTE: The WCA does not allow employers and/or employees to pay for medical bills out of pocket. This practice may result in fines. Please provide the injured worker with the claim number generated after the report is entered into ICE as well as CCMSI contact information.

FIRST AID

1) Administer first aid to the injured worker.
2) Ask your employee to complete and sign a **"Notice of Accident"** form.
3) Fill out the ICE report online within 24 hours (72 hours at the latest).

For Your Protection:

First Aid kits should be available to employees on every job site.

- OSHA requires that all job sites have at least one employee trained in first aid.
- Prompt attention to first-aid-only injuries can prevent them from becoming expensive claims.

NOTICE OF ACCIDENT

CCMSI recommends that employers require their injured workers to complete and sign a "Notice of Accident" form for all types of accidents. This allows the injured worker to document their accident.

After the NOA form is completed, the employer should give a copy to the injured worker and upload a copy into the workers claim on ICE.

The “Notice of Accident” forms can be printed from NMPSIA.com. The poster and a supply of "Notice of Accident" forms must be posted for employee use. Additional posters can be obtained at no charge from the nearest WCA office or call CCMSI.

A T T E N T I O N !

- **Report** Injuries. There have been many instances in which an employer does not report a claim because they feel it is not valid. In some instances, the first time CCMSI was notified of an injury was when the injured worker filed for mediation through the WCA.
- **If an employee reports an on** the job injury to you that requires medical attention, **you** are required by law to file a claim even if you don't feel the claim is valid.
- Never pay for a claim directly. If you receive bills from a medical provider, forward them immediately to CCMSI. They will file all reports on your behalf and pay all medical and indemnity costs for compensable claims. CCMSI uses statutory and negotiated discounts from providers which decrease the cost of the claim.
- Make sure and notify CCMSI immediately when you find out about a claim. Late reporting can result in assessments or fines to you from NMPSIA or the Workers' Compensation Administration. Delays in reporting can also result in increased claims costs and may hinder any investigation that CCMSI may need to conduct.

BE PREPARED BEFORE A WORK COMP INJURY OCCURS!

DOES YOUR SCHOOL HAVE WRITTEN
WORKERS' COMPENSATION POLICY, REGULATION, OR PROCEDURE?
IF NOT, FIND THE OPTION THAT FITS YOUR SCHOOL AT
NMPSIA.COM

DIFFERENCE – WORKERS' COMPENSATION POLICY or PROCEDURE – ***OPTION 1-A***

- **Employer Selects** Initial Health Care Provider;
- Injured Worker may use **Leave** (Sick, Vacation or PTO) **for the 7-Day Waiting Period Only**;
- Injured **Worker is Responsible for their Portion of Insurance Premiums** while Disabled as a result of a Compensable Industrial Injury;

DIFFERENCE – WORKERS' COMPENSATION POLICY or PROCEDURE – ***OPTION 2-A***

- **Worker Selects** Initial Health Care Provider;
- Injured Worker may use **Leave** (Sick, Vacation or PTO) **for the 7-Day Waiting Period Only**;
- Injured **Worker is Responsible for their Portion of Insurance Premiums** while Disabled as a result of a Compensable Industrial Injury;

DIFFERENCE – WORKERS' COMPENSATION POLICY or PROCEDURE – ***OPTION 3-B***

- **Employer Selects** Initial Health Care Provider;
- Injured Worker may use **Leave** (Sick, Vacation or PTO) **until Accumulated Leave has been Exhausted**;
- Injured Worker is allowed to have their Portion of **Insurance Premiums, Retirement Contributions, etc., deducted from Payments of their Accumulated Leave** until the Accumulated Leave has been Exhausted;

DIFFERENCE – WORKERS' COMPENSATION POLICY or PROCEDURE – ***OPTION 4-B***

- **Worker Selects** Initial Health Care Provider;
- Injured Worker may use **Leave** (Sick, Vacation or PTO) **until Accumulated Leave has been Exhausted**;
- Injured Worker is allowed to have their Portion of **Insurance Premiums, Retirement Contributions, etc., deducted from Payments of their Accumulated Leave** until the Accumulated Leave has been Exhausted;

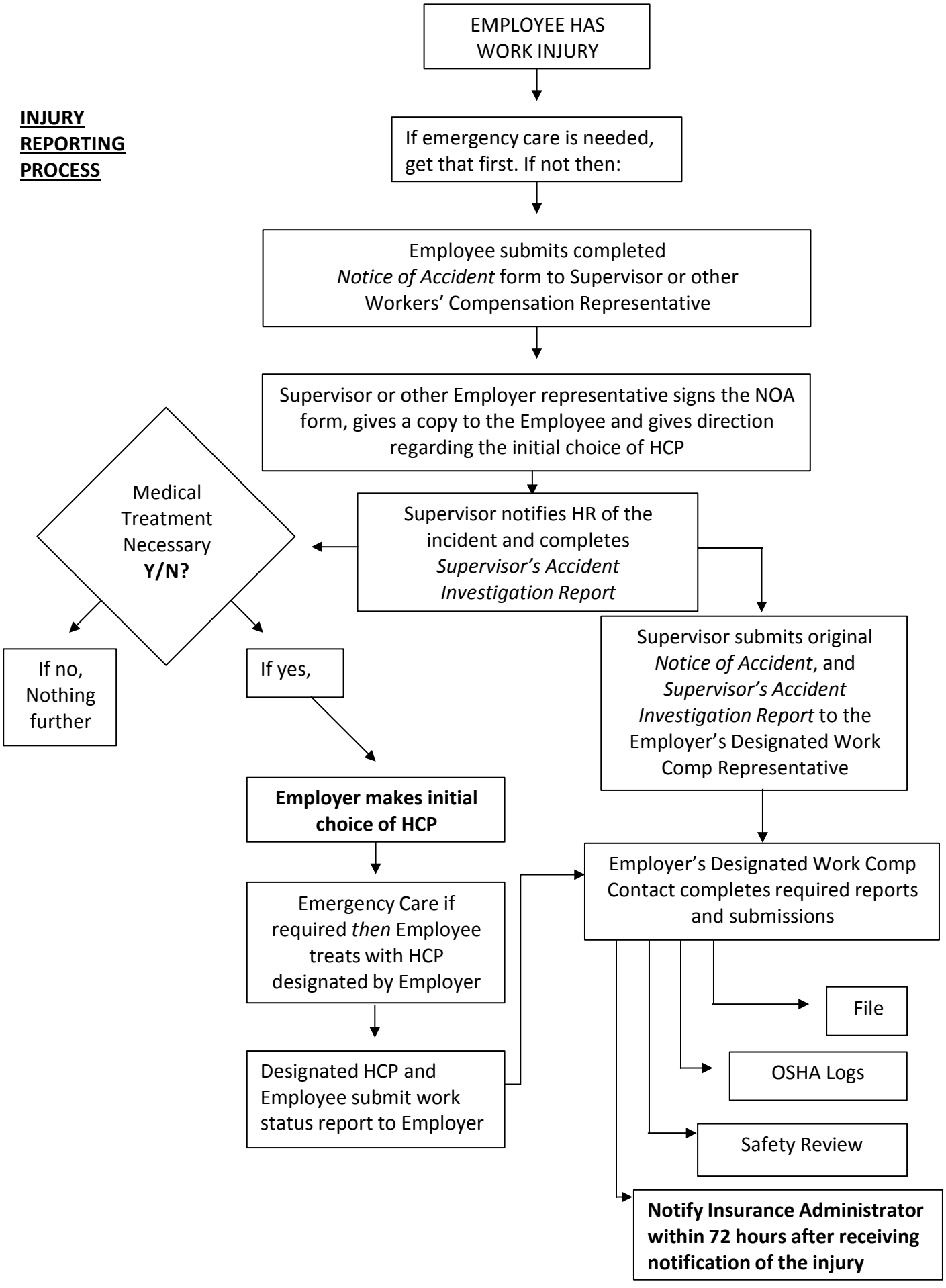
Next page:

EXAMPLE OF INJURY REPORTING PROCESS IF

EMPLOYER **MAKES THE INITIAL SELECTION OF**

HEALTH CARE PROVIDER

INJURY REPORTING PROCESS



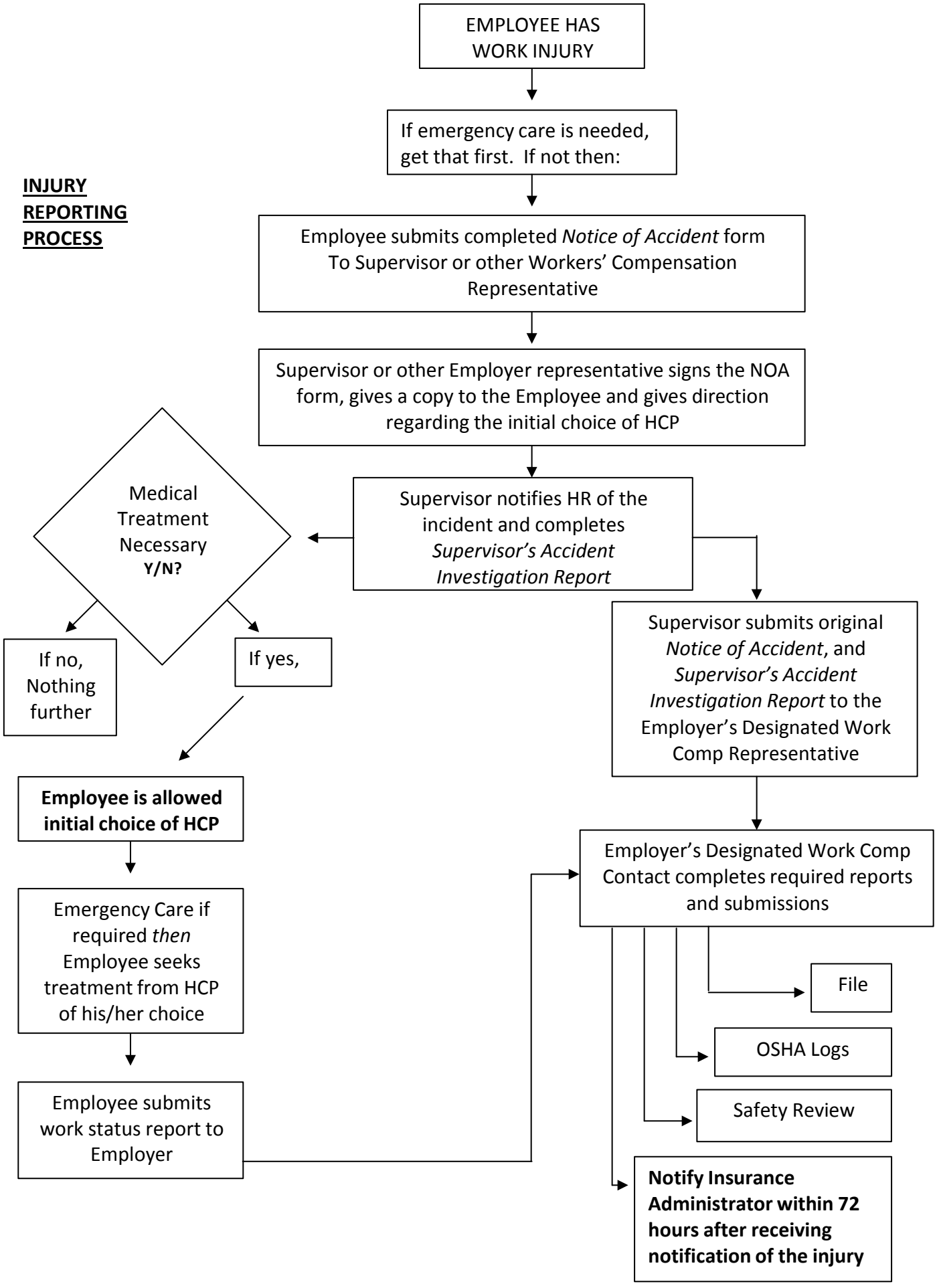
Next page:

EXAMPLE OF INJURY REPORTING PROCESS IF

WORKER **MAKES THE INITIAL SELECTION**

OF HEALTH CARE PROVIDER

INJURY REPORTING PROCESS



WORKERS' COMPENSATION POSTER AND NOTICE OF ACCIDENT FORMS

Employers are required to post the workers' compensation poster with the Notice of Accident (NOA) forms at their workplace. The NOA forms are to be attached or adjacent to the poster. The following is a quote from the New Mexico Workers' Compensation Rule regarding this matter:

11.4.2.10 ACCIDENT NOTICE POSTERS AND ACCIDENT NOTICES:

A. Every employer shall post and keep posted in conspicuous places on its business premises, in areas where notices to employees and applications for employment are customarily posted, an accident notice poster stating the requirement that workers notify employers of accidents. The accident notice poster is available at the WCA at no charge to the employer on a form approved by the director.
B. Every employer must keep attached to the accident notice poster an adequate supply of notice of accident forms approved by the director.
C. Any employer may submit to the director a proposal for approval of a notice of accident form or accident notice poster. No form shall be approved except in writing, signed by the director.

For your consideration, there are three different NOA forms available in this document and on the NMPSIA.com website that are approved by the director. ***Only one of the three is to be used at your school***.

1) Form NOA-1-W, is the official NOA form provided by the WCA and is used by Employers in New Mexico who make the initial selection of health care provider or allow the Worker to make the initial selection.
2) **Form NOA-1-NMPSIA 2015**, is a form approved for NMPSIA by the WCA director. This form is used by **schools that make the initial selection of health care provider.**
3) **Form NOA-2-NMPSIA 2015**, is a form approved for NMPSIA by the WCA director. This form is used by schools that **allow the worker to make the initial selection of health care provider.**

Because the party that makes, or is allowed the initial selection, has the right to that selection for only 60 days, ***a school's policy to make the initial selection of health care provider or allow the worker to make the initial selection carries significant consequences!*** For most schools in New Mexico, we recommend the policy to allow the injured worker to make the initial selection of health care provider. The following is a quote from the New Mexico Workers' Compensation Statute regarding this matter:

52-1-49. Medical and related benefits; selection of health care provider; artificial members.

A. The employer shall initially either select the health care provider for the injured worker or permit the injured worker to make the selection. Subject to the provisions of this section, that selection shall be in effect during the first six days from the date the worker receives treatment from the initially selected health care provider.
B. After the expiration of the initial sixty-day period set forth in Subsection B of this section, the party who did not make the initial selection may select a health care provider of his choice. Unless the worker and employer otherwise agree, the party seeking such a change shall file a notice of the name and address of his choice of health care provider with the other party at least ten days before treatment from that health care provider begins...

Next page:

WORKERS COMPENSATION POSTER

Produced by the
New Mexico Workers' Compensation Administration

In the blocked section designated for the "Employer's Insurer / Claims Representative" Please insert one of the following statements:

*****

The (NAME of ENTITY) permits Employees the initial selection of health care provider (HCP) for work related injuries or conditions.

The Insurer/Claims Representative for (NAME of ENTITY) is:

CCMSI
(Cannon Cochran Management Services, Inc.)
PO Box 30870
Albuquerque, NM 87190
505-837-8700 / 800-635-0679

Please review the (NAME of ENTITY) Employee Handbook or contact Human Resources for additional information regarding Attendance and Illness Policies and Procedures.

*****

The (NAME of ENTITY) chooses to select the initial health care provider (HCP) for work related injuries or conditions.

The Insurer/Claims Representative for (NAME of ENTITY) is:

CCMSI
(Cannon Cochran Management Services, Inc.)
PO Box 30870
Albuquerque, NM 87190
505-837-8700 / 800-635-0679

Please review the (NAME of ENTITY) Employee Handbook or contact Human Resources for additional information regarding Attendance and Illness Policies and Procedures.

State of New Mexico Workers' Compensation Administration

WORKERS' COMPENSATION ACT

If You Are Injured At Work
Si Se Lastima En El Trabajo

1) Notice -- In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) You have the right to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

3) Claims information -- Contact your employer's Claims Representative.

1) Aviso. -- En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) Usted tiene el derecho a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) Información acerca de Reclamaciones. -- Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

Name: _____

Phone #: _____

Address: _____

_____

Note: Employer must fill in this insurer / claims representative information.

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than 7 days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es el que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

Ombudsmen are located at the following offices:

Albuquerque:	Farmington:	Las Cruces:	Las Vegas:	Lovington:	Roswell:	Santa Fe:
1-800-255-7965	1-800-560-7310	1-800-870-6826	1-800-281-7889	1-800-934-2450	1-866-311-8587	1-505-476-7381
1-505-841-6000	1-505-599-9746	1-575-524-6246	1-505-454-9261	1-575-396-3437	1-575-623-3997	

If You Need HELP Call:

Ask for an Ombudsman

Si Usted Necesita Ayuda Llame Al:

Pregunte por un Ombudsman

1 - 8 6 6 - W O R K O M P (1-866-967-5667)

Visit our website at: www.workerscomp.state.nm.us

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it. This poster without Notice of Accident forms does not comply with law. You have other rights and duties under the law.

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

POST FORMS HERE

This poster published 5/13/07. It remains valid until reissued and supersedes all prior versions except 5/13/05.

Next page: NOTICE OF

ACCIDENT
Form NOA-1-W

Produced by the
New Mexico Workers' Compensation Administration

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 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)

Next page:

Approval letter from the Director of the New Mexico Workers' Compensation Administration allowing alternative Notice of Accident forms for NMPSIA

State of New Mexico
WORKERS' COMPENSATION ADMINISTRATION

SUSANA MARTINEZ
GOVERNOR

DARIN A. CHILDERS
DIRECTOR

P.O. BOX 27198
ALBUQUERQUE, NM 87125-7198
(505) 841-6000
WWW.WORKERSCOMP.STATE.NM.US

September 16, 2015

Mr. Henry F. Narvaez
NARVAEZ LAW FIRM, P.A.
P.O. Box 25967
Albuquerque, NM 87125-0967

Re: Alternative workers' compensation Notice of Accident forms for NMPSIA

Dear Mr. Narvaez:

Thank you for your letter of 9/8/15 regarding a request for approval of alternative workers' compensation Notice of Accident forms. I have reviewed the request and the proposed forms and notify you that they are APPROVED for use by members of the New Mexico Public Schools Insurance Authority ("NMPSIA") pursuant to NMSA 1978, §§ 52-1-29 and 52-3-19.

Please advise your client, NMPSIA, to keep sufficient copies of this letter for future reference in the event there is a question about the appropriateness of the forms.

Thank you for your assistance and best wishes to you and to NMSPIA!

Sincerely,

Darin A. Childers

Next page:

Alternative
NOTICE OF ACCIDENT Form
NOA - 1 – NMPSIA 2015

EMPLOYERS' INITIAL SELECTION OF HEALTH CARE PROVIDER

Produced by the
New Mexico Public Schools Insurance Authority

Approved by the Director of the
New Mexico Workers' Compensation Administration

RESET FORM

Individual Alternative Notice of Accident Form (NOA-1 Employer's Choice) 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: _____
Número de seguro social del empleado:

Employee's Home Address: _____
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?

_____

_____

Employer will choose health care provider. Worker has right to change health care provider after 60 days
El empleador elegirá el proveedor de atención médica. Trabajador tiene el derecho de cambiar el proveedor de atención médica después de 60 dias

Employer's choice of health care provider is:
La elección del empleador de proveedor de cuidado de la salud es: _____
_____
_____

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 clinica / 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 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

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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- NMPSIA 2015

Next page:

Alternative
NOTICE OF ACCIDENT Form
NOA - 2 – NMPSIA 2015

WORKERS' INITIAL SELECTION OF HEALTH CARE PROVIDER

Produced by the
New Mexico Public Schools Insurance Authority

Approved by the Director of the
New Mexico Workers' Compensation Administration

RESET FORM

Individual Alternative Notice of Accident Form (NOA-2 Employee's Choice) 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 dias

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 clinica / 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 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-2- NMPSIA 2015

WORKERS' COMPENSATION CLAIMS REPORTING REQUIREMENTS AND CONDUCT OF THE PARITES

As required by the New Mexico Workers' Compensation Administration, NMPSIA request that ALL work accidents, injuries or diseases be submitted to CCMSI. The delivery of benefits payments, management of medical care and payment of bills are the services provided to assure your injured employee gets back on the job as soon as possible. THE NEW MEXICO REGULATORY AUTHORITIES ASSESS SEVERE PENALTIES FOR FAILURE TO PROMPTLY RESPOND TO WORKERS' COMPENSATION CLAIMS.

Prompt reports of injuries help us gather the necessary facts so we can pay for injuries that are work-related, and defend your school against those that are not. As documented in the following excerpt from rule 11.4.3.13.B(4) injuries should be reported to CCMSI within **seventy-two (72) hours** after the worker notifies the employer. The following is a quote from the New Mexico Workers' Compensation Rule regarding this matter:

11.4.3.13 CONDUCT OF PARTIES:

B. Employer's duties:

(4) The employer shall report every accident to their insurer or, in the case of a self-insured employer or member of a self-insurance group, their claims administrator, whether or not the employer considers the claim to be valid, within 72 hours of the earlier of:

(a) actual knowledge of the accident by the employer; or

(b) presentation of a notice of accident form to the employer.

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS TO BE SUBMITTED ELECTRONICALLY

As of January 1, 2017, paper copies of the NM WCA FORM E1.2, are no longer accepted by the Workers' Compensation Administration (WCA). The NM WCA FORM E1.2, which is also known as the First Report of Injury (FROI), shall only be submitted through electronic data interchange (EDI) or the WCA website. The following is a quote from the New Mexico Workers' Compensation Rule regarding this matter:

11.4.2.8 DATA COLLECTION:

A. General provisions:

(1) Paper copies of FROI and SROI will not be accepted by the WCA as of January 1, 2017. Beginning January 1, 2017, FROI and SROI data shall only be submitted through EDI or the WCA website.

Please do not send paper forms to the WCA. CCMSI accepts Workers' Compensation First Reports of Injury electronically from the employer via the ICE (Internet Claims Edge) system. CCMSI then submits the First Report and any other applicable forms to the WCA through electronic data interchange (EDI).

Please contact CCMSI at 800-635-0679 and request a secure identification number to submit claims electronically using ICE (Internet Claims Edge).

Next page:

Copy (old paper form) of
EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS
Although this form is no longer used to report work injuries to the New Mexico Workers' Compensation Administration, it can be completed by the employer in urgent situation and faxed or emailed to CCMSI. The dedicated fax and email information is:
FAX: 505-888-6794
EMAIL: nmpsiawc@ccmsi.com

***** PLEASE NOTE *****
All Workers' Compensation claims should be filed to CCMSI electronically through the ICE (Internet Claims Edge) system. This form of the Employers' First Report of Injury is to be completed and presented to CCMSI *only* when the employer does not have an ICE login ID. If your school does not have an ICE login ID, please email nmpsiawc@ccmsi.com with the name, job title, email address and telephone number of the person designated to submit workers' compensation claims to CCMSI.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

2410 CENTRE AVE. SE ♦ PO BOX 27198
ALBUQUERQUE, NM 87125-7198

Individual Employers' First Report of Injury or Illness Form

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)
NMPSIA
410 Old Taos Hwy,
Santa Fe, NM 87501

CARRIER FEIN
850365637

POLICY PERIOD
TO

CHECK IF APPROPRIATE
☒ SELF INSURANCE

POLICY / SELF-INSURED NUMBER

AGENT NAME & CODE NUMBER

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

OF DEPENDENTS

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

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

Completion of this form is not an admission that the claim is compensable under the Workers' Compensation Act.

Next page:

Example of
SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Individual Supervisor's Accident Investigation Report Form

<table>
<tr><td rowspan="5">GENERAL INFORMATION</td><td colspan="2">DEPARTMENT</td><td>SHIFT</td></tr>
<tr><td colspan="2">EMPLOYEE NAME</td><td>JOB TITLE</td></tr>
<tr><td colspan="2">EMPLOYEE NUMBER</td><td>SEX (M/F)</td></tr>
<tr><td colspan="3">TYPE OF ACCIDENT/ILLNESS</td></tr>
<tr><td colspan="3">TYPE OF INJURY</td></tr>
<tr><td>PART OF BODY INJURED</td><td>TREATMENT
☐ FIRST AID ☐ MEDICAL</td><td>DID EMPLOYEE RETURN TO WORK THE SAME DAY?
☐ YES ☐ NO</td></tr>
<tr><td>DESCRIPTION</td><td colspan="3">WHERE DID THE ACCIDENT HAPPEN? USE ADDITIONAL SHEETS IF NECESSARY</td></tr>
<tr><td rowspan="4">CAUSES</td><td colspan="3">SPECIFIC MACHINE, TOOL, SUBSTATNCE OR OBJECT CONNECTED WITH THE ACCIDENT</td></tr>
<tr><td colspan="3">UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIME OF ACCIDENT (Be Specific)</td></tr>
<tr><td colspan="3">PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)
PERSONAL PROTECTIVE EQUIPMENT REQUIRED</td></tr>
<tr><td colspan="3">WAS INJURED EMPLOYEE USING REQUIRED EQUIPMENT?</td></tr>
<tr><td>RECOMMENDATIONS</td><td colspan="3">ACTION PLAN TO PREVENT RECURRENCE (Modification of Machine, Mechanical Guarding, Environment, Training)

_____ _____
SUPERVISOR'S SIGNATURE DATE</td></tr>
<tr><td>FOLLOW-UP</td><td colspan="3">ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)</td></tr>
</table>

Next page:

Example of
REPORT OF WORK ABILITY
To be given to the injured worker immediately following their injury so they can take it to their initial evaluation with the health care provider.

***** PLEASE NOTE *****
The Employee Information at the top of the Report of Work Ability, including the claim number, can be completed by the Employer before giving the document to the injured worker to take to the health care provider.

REPORT OF WORK ABILITY

EMPLOYEE:	***1. PLEASE HAVE EACH HEALTHCARE CLINICIAN COMPLETE THIS FORM AT EACH VISIT TO THE CLINICIAN:*** ***2. PLEASE PROVIDE A COPY OF THE COMPLETED FORM TO YOUR SUPERVISOR AFTER EACH VISIT***
CLINICIAN:	***PLEASE COMPLETE, SIGN AND FAX THIS FORM TO EMPLOYMENT SERVICES AT:***

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial_____

Employee ID# _____ Date of Birth _____ Date of Injury/Illness _____ Job Title/Description _____ Phone _____

Employer_____ Supervisor or Contact_____ Employer Phone_____

Worker's Compensation Administrator/Billing Information **Claim Number** _____
CCMSI, P.O. Box 30870, Albuquerque, NM 87190 505-837-8700

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize my medical provider to release or exchange information acquired in the course of my examination or treatment for the following medical condition to my employer or employer representative.
Patient Signature:_____ Date: _____

TREATING PROVIDER'S EVALUATION-COMPLETE IN FULL FOR EACH VISIT

Treatment Date_____ For: ☐ Initial Treatment ☐ Follow-up Appointment

Nature of Visit: ☐ Work Related ☐ Not Work Related ☐ Unknown

Describe Circumstances of the Injury/Illness:_____
Diagnosis:_____
Treatment:_____

Medication Prescribed Could Cause Drowsiness or Impair Ability and/or Operate Heavy Equipment: ☐ Yes ☐ No

Maximum Medical Improvement Reached: ☐ Yes ☐ No Date of MMI: _____

Impairment Rating (PPD) if applicable: _____
Referral/Consult: _____
Next Appointment: Date: _____ Time: _____ Doctor: _____

EMPLOYEE CAPABILITIES

Employee is released from care and has no restrictions.

☐ **May return to work with no restrictions:** ☐ Immediately, or ☐ Beginning _____

☐ Injury will result in loss of time from work: from _____ through _____

☐ May return to work with the following restrictions:_____
from _____ through _____

☐ Estimated Return to Full Duty is: _____/_____/_____

TREATING PROVIDER

Provider Name (please print) _____Clinic Name _____

Provider Signature _____Clinic Address _____

Next page:

Example of Initial Notice of Workers' Compensation Administrator and FAMILY MEDICAL LEAVE ACT

To be mailed or emailed to the injured worker following the incident. The FMLA certification form (WH-380-E) that is to be attached to the letter can be located at https://www.dol.gov/

***** PLEASE NOTE *****

If your school or the Injured Worker does not qualify for FMLA or other protected leave, ongoing employment or termination should be based on your policies.

DATE

Name of Injured Worker
Worker's mailing address

Re: Worker's Compensation Claim XXH01XXXXXX
Incident Date: 00/00/2016

Dear (Name of injured employee),

The purpose of this letter is to provide you the contact information of the administrator of our workers' compensation claims (CCMSI) as well as a copy of the certification form pertaining to the Family Medical Leave Act (FMLA).

CCMSI
P.O. Box 30870
Albuquerque, NM 87190-0870
1-800-635-0679

If you obtain medical attention related to the above referenced work incident, please provide us with a work status report from the health care professional that is treating you. A work status report from the treating health care professional is required prior to consideration of returning to work. Please have the health care professional complete their portion of the FMLA provided. This is required if you are absent more than three days. Provide the health care professional with the claim number and contact information mentioned above.

Please contact me if you have any questions regarding this matter.

Sincerely,

Name
Human Resource Specialist
Name of School District
(505) XXX-XXXX
Fax (505) XXX-XXXX

Enclosure/Attachment: Form WH-380-E

MANAGEMENT OF THE INJURY

Management of a worker's injury and medical care is the responsibility of everyone involved, the employer, the worker, and the claims adjuster. The following is a list of steps the employer should take when a worker reports an injury.

Immediate Response:

- Inform the injured employee of the school's policy regarding initial selection of the health care provider. If the injury requires immediate care, direct the injured employee to the emergency room
- Notify the employee's family of the injury. This is only necessary in serious injuries.

Follow-up Response:

- Contact the injured employee following medical care
  - Be sympathetic towards the injured worker.
  - Express concern for the injured worker.
  - Be positive and reassuring about the employee returning to work.

Investigate Accident:

- Investigate the accident circumstances as soon as possible after the accident, preferably the same day.
- Investigate the scene immediately.
- Talk to witnesses.
- Preserve any contributing items or causes of the accident.
- Preserve any video taken of the area at the time of the alleged accident.
- Relay all pertinent information to the CCMSI Claims Department.
- Inform the CCMSI Claims Department if you suspect drug or alcohol involvement.

RETURN TO WORK

Returning injured employees to work quickly is the most effective and important way of reducing costs on your workers' compensation cases. Your goal should be to return the injured employee to the same job in your organization, as quickly as possible.

If the injured employee cannot immediately return to his or her regular job, you should attempt to return the employee to work, in a modified job. A modified job is the employee's regular job changed in such a way that the employee can work during the period of recovery, within the restriction of activity assigned by the attending physician. This arrangement is anticipated to be a temporary one, with the employee always resuming unlimited regular work sometime in the future. Modified work can often involve a wage loss and a continuing, but reduced, workers' compensation liability.

When employees cannot perform modified work, or the employer does not have such work available, the next goal would be to place the employee in an alternate job. Alternate work can be defined as a different job from the regular job, but one that is within the restrictions of activity assigned by the physician. This is a temporary position with the return to regular work as the ultimate goal.

The modified duty job offer is to be in written rather than verbal format.

Failure of the employee to accept the modified work, which you have made available, may result in the discontinuance of their bi-weekly benefits. You must notify CCMSI immediately if the injured worker refuses modified work.

The following guidelines were designed to assist you in the steps necessary to return an employee to work. Each individual involved has certain responsibilities outlined as follows:

A. Treating Physician's Responsibilities

1. Provide Documentation

   - Return to work date
   - Restrictions
   - Date/time of next follow up appointment

2. Provide medical reports to the claims adjuster.

B. Employee's Responsibilities

1. Present self to employer on scheduled return-to-work date.

2. Provide employer with documentation

   - Work status report from health care provider
   - Signed medical authorization form
   - Signed modified duty job offer and retrn to work agreement

3. Inform employer of next appointment date/time with treating physician.

4. Provide employer with additional pertinent information of accident investigation, if necessary.

5. Keep all follow-up appointments with treating physician.

C. Employer's Responsibilities

1. Notify (by telephone) CCMSI claims adjuster.

   - Release to return-to-work date
   - Restrictions (if any)
   - Next appointment date

2. Notify employee's supervisor of return to work

   - Restrictions (if any)
   - Next scheduled doctor appointment date/time

3. Run FMLA concurrently with Workers' Compensation disability dates.

D. Responsibilities of Employee's Supervisor

1. Provide temporary light duties approved by treating physician and employer for modified return to work.

2. Emphasize the importance of the employee's return-to-work continuance.

3. Review new and old safety precautions with the employee.

4. Provide time off from work for scheduled doctor appointments relative to the employee's injury.

Next page:

Example of
MODIFIED DUTY JOB OFFER

SAMPLE LETTER OF MODIFIED DUTY

(COMPANY LETTER HEAD)

(CERTIFIED MAIL-RETURN RECEIPT)

(Date)
(Injured worker & address)

Re: Modified duty job offer for temporary assignment

Dear (Injured worker's name),

After reviewing the information provided by your doctor, we are pleased to offer you the following temporary, modified duty work assignment.

We believe this work assignment is within your capabilities as described by your doctor. You will be assigned tasks consistent with your physical abilities and skills.

Job Title: _____

Job Duties: _____
_____
_____
_____

Location: _____ Start date: _____
Work hours: From (_____) to (_____) Wages: _____
Supervisor: _____

This temporary, modified duty work assignment (in combination with any missed work time); will not last longer than twelve weeks.

Return this form to us by _____indicating if you accept the temporary modified duty job. If we do not hear from you by the start date, it is understood you have refused the job offer.

___ I accept the temporary job offer ___ I do not accept the temporary job offer

_____ _____
Injured worker's signature Date

A refusal of the job offer may impact your temporary income benefit payments. If you have a concern, please contact us or your adjuster at CCMSI 800-635-0679.

Sincerely,
(Name & title)

Next page:

Example
MODIFIED DUTY CHECKLIST

INJURED EMPLOYEE CHECKLIST
TEMPORARY MODIFIED DUTY PROGRAM

____ _____ is the person designated as your contact person in Administration or Human Resources. Telephone number _____

____ Modified duty is a temporary placement in a position that can accommodate your limitations/restrictions resulting from your work related injury. The job assignments are temporary in nature and you may be asked to move to another job or location as the need arises.

____ Modified duty assignments (in combination with any missed work time), will not last longer than twelve weeks. Modified duty assignments will also end when:

- You return to your regular job at full capacity;
- You are placed at Maximum Medical Improvement (MMI) by the health care provider.
- Your physical restrictions change, making continued modified duty impractical.

____ If you are unable to transfer to a position that meets your qualifications and your work-related restrictions before the end of the 12-week period, your employment will be terminated.

____ While on modified duty, you will be asked to keep both your supervisor and your employer's designated contact person informed of your work status. This means that both individuals should be contacted following each visit to your treating physician.

____ The person that you report to in your modified duty assignment should be kept informed (in advance) of all scheduled appointments so that the workload can be appropriately assigned.

____ If you have been asked by the supervisor of your temporary job to do something outside your restrictions, you must remind the supervisor of your restrictions, – DO NOT participate in any work activity that is outside of the restrictions placed on you by your treating physician. If you are experiencing pain or other problems as a result of the work you have been asked to perform, contact your physician and report the problems to the employer's designated contact person immediately.

____ If you are unable to report to work for any reason, you must contact the supervisor of the area where you have been temporarily assigned, as well as the employer's designated contact person before the beginning of your scheduled shift. Attendance expectations do not change while in a modified duty position.

____ If you have been released to work only part-time by your treating physician and your normal schedule is full-time, you might be offered modified duty that meets the part-time restrictions from your physician. You will be eligible to receive a "temporary partial disability" payment from workers' compensation for the remaining missed wages. This is not a direct dollar-for dollar compensation but is pro-rated based on New Mexico State Workers' Compensation Statutes. For more information regarding "temporary partial disability", please contact your claims adjuster (your employer's designated contact person can provide you with the name and telephone number of your adjuster).

____ You are not required to work modified duty. This is offered to you as an alternative so that you can continue to receive your salary while you are recuperating from your work-related injury. You have the option of not returning to work and being placed on a leave of absence. However, you need to be aware that if there is work available to you and you choose to remain off work, you will not receive any lost wage benefits through workers' compensation.

____ If you have problems in your modified duty assignment, you may ask to be reassigned to a different area. Please contact your employer's designated contact person.

____ From time to time, medical case managers will be assigned to facilitate your medical care and treatment plan. Medical case managers are generally assigned when there are complicating factors (i.e., multiple injuries, surgery, unusual diagnoses, long courses of treatment, etc.)

____ I, the employee, have accepted the agreement.

____ I, the employee, **do not** accept the agreement.

_____ _____

Employee Signature Date

_____ _____

Employer Representative Signature Date

SECTION 2

PROPERTY AND LIABILITY CLAIMS REPORTING REQUIREMENTS

WHAT IS COVERED UNDER THE PROPERTY AND LIABILITY PROGRAM?

The coverage provided through NMPSIA is extremely broad and offers coverage for most situations that might arise in a school setting or in connection with school operations. If you have a situation where you are unsure what to do, please contact the CCMSI office with any questions.

REPORTING AN OCCURRENCE?

In an emergency, please contact the CCMSI office *IMMEDIATELY* by telephone.

If you have a situation that requires prompt action but is not an emergency, please contact us by telephone *ASAP*.

For reporting non-emergent situations, please fax completed forms to:
Property and Liability Fax: 505-888-6901

WHAT FORMS ARE USED FOR PROPERTY AND LIABILITY CLAIMS?

- Student Accident Report
- Vehicle Accident Report
- Loss Report, Property
- General / Products Liability
- Windshield Only

STUDENT ACCIDENT REPORT

The Student Accident Report is to be used for any bodily injuries or medical incidents that happen to a student or students on school premises or during school sponsored activities. Examples include:

- Slip/Falls
- Fights
- Sports Injuries
- Playground Injuries

A copy of the Student Accident Report form is on the following page.

RESET FORM

Individual Student Accident Report Form

CONFIDENTIAL, THIS REPORT IS NOT TO BE RELEASED TO PARENT AND/OR STUDENTS

The school employee either witnessing the accident or supervising at the time should complete and submit this form within 24 hours.

IN CASE OF SERIOUS INJURIES, A TELEPHONE REPORT IS TO BE MADE IMMEDIATELY

1. School District _____

2. School _____ Address _____

3. Student's Name _____ DOB _____ Grade _____

4. Student's Address _____
   Telephone Number _____

5. Where did accident occur? _____ Date _____ Time _____ A

6. Describe how accident occurred _____

_____

7. Who was the person in charge at the time of the accident? _____
   Was he present at the time? ☐ Yes ☐ No Did the injured violate any schools rule? ☐ Yes ☐ No

8. Witnesses: _____ Witnesses: _____
   Address: _____ Address: _____
   Phone: _____ Phone: _____

9. Apparent Nature of Injury:

☐ Abrasion ☐ Fracture ☐ Strain/Sprain
☐ Contusion ☐ Cut ☐ Dislocation
☐ Internal ☐ Concussion

10. Injured Part of Body: Indicate R/L

☐ Head ☐ Finger ☐ Arm ☐ Abdomen
☐ Neck ☐ Eye ☐ Leg ☐ Hand
☐ Back ☐ Chest ☐ Face ☐ Foot

11. First aid procedures used _____ By whom _____

12. Disposition of injured after accident- Class ☐ Home ☐ Doctor ☐ Hospital ☐ _____

13. Who was notified? _____ Relationship to injured student? _____

14. If injured student left school, to whom released? _____

15. Name and attitude of anyone contacting school _____

_____

16. Student accident benefits available? Name of company _____

17. Remarks _____

18. Report completed by _____ Approved by _____ Date _____

VEHICLE ACCIDENT REPORT

For any school owned vehicle. Examples include:

- Bus
- Superintendent cars
- Pool cars
- Maintenance vehicles
- Contractor bus

A copy of the Vehicle Accident Report form is on the following page.

RESET FORM

Individual Vehicle Accident Report Form

NEW MEXICO
PUBLIC SCHOOLS INSURANCE AUTHORITY

Cannon Cochran Management Services, Inc.
Claims Administrator
P.O. Box 30870
Albuquerque, New Mexico 87190-0870
800-635-0679 505-837-8700
505-888-6901 Fax

C C M S I

Vehicle Accident Report

(For bodily injury or damage to another's property or for damage to your vehicle)

District Name	Address			City	State	Zip	Phone						
School/Dept. Name	Address			City	State	Zip	Phone						
Driver's Name	Address			City	State	Zip	Phone						
Date of Birth	Social Security No.			Driver's License No.									
Vehicle													
Make	Year	Model	Serial #	License #	Where Vehicle May be Seen								
Trailer	Year	Model	Area of Damage	Used for Business? ☐ Yes ☐ No	Estimated Cost to Repair $								
Accident													
Date of Loss	Time of Loss	Location (Street/Highway)		City	State								
Were Police Called to Scene? ☐ Yes ☐ No	Police Dept. Called	Driver	Arrested?	Ticketed?	Violation?								
Name of Officer	Station Address												
Claimant 1													
Owner of Other Vehicle	Age	Address	City	State	Zip	Phone							
Driver, if other than above	Age	Address	City	State	Zip	Phone							
Make	Year	Model	License #	Area of Damage	Where Vehicle May Be Seen	Estimate of Damage $							
Claimant 2													
Owner of Other Vehicle	Age	Address	City	State	Zip	Phone							
Driver, if other than above	Age	Address	City	State	Zip	Phone							
Make	Year	Model	License #	Area of Damage	Where Vehicle May Be Seen	Estimate of Damage $							
Property Damage – Other Than Auto (ie, Fence, Canopy)													
Owner of the Property	Address	City	State	Zip	Phone								
Describe Damaged Property	Location of Property	Extent of Damage											
Witness Information													
Name	Address	City	State	Zip	Phone								
Name	Address	City	State	Zip	Phone								

Vehicle Accident Report

Page 2

Name	Address	City	State	Zip	Phone

Occupation	Age	Where Taken Following Accident

Pedestrian	☐	Fatality	☐	No Visible Injury – Some Pain	☐
In Your Vehicle	☐	Bleeding/Wound	☐	Other	
In Claimant Vehicle	☐	Unconscious	☐		

Name	Address	City	State	Zip	Phone

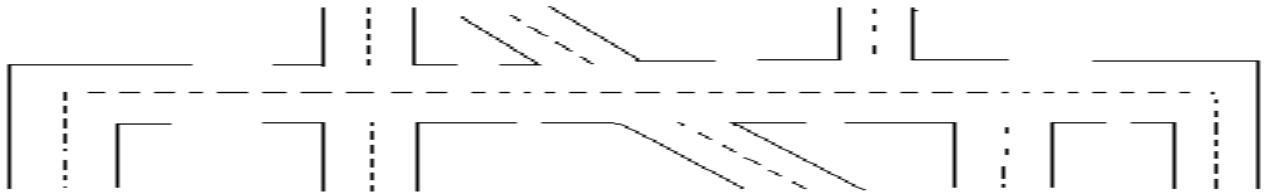
Occupation	Age	Where Taken Following Accident

Pedestrian	☐	Fatality	☐	No Visible Injury – Some Pain	☐
In Your Vehicle	☐	Bleeding/Wound	☐	Other	
In Claimant Vehicle	☐	Unconscious	☐		

Additional Remarks

Describe Accident Accident Resulted In: ☐ Bodily Injury ☐ Prop. Damage ☐ Vehicles ☐ Pedestrian

Accident Diagram



Note: Indicate North By Arrow

What Street Were You On?	Claimant 1	Claimant 2
What Direction Were You Traveling?	Claimant 1	Claimant 2

Weather Conditions	Traffic Conditions
Dry ☐ Wet ☐ Icy ☐ Foggy ☐ Snowy ☐	Light ☐ Moderate ☐ Heavy ☐

Speed Limit	Were You Familiar With The Area?	Traffic Controls

This Section Must Be Completed By Your Supervisor

1. Do you think a claim will be made against you? Yes ☐ No ☐
2. In my opinion, we are at fault for this accident? Yes ☐ No ☐

IMPORTANT: Has this accident been reported to a CCMSI adjuster? Yes ☐ No ☐

If reported, name of adjuster _____

Signature/Title _____ Date _____

PROPERTY LOSS REPORT

Examples include:

- Building and/or Contents
- Employee Dishonesty
- Robbery or Burglary

A copy of the Property Loss Report form is on the following page.

RESET FORM

Individual Property Loss Report Form

LOSS REPORT, PROPERTY

NAME OF COMPANY/CLIENT LOCATION **District:**		PHONE NUMBER	
ADDRESS	CITY	STATE	ZIP
LOCATION OF LOSS			
DATE OF LOSS	TIME OF LOSS	ESTIMATE OF LOSS	

BUILDING AND/OR CONTENTS

DETAILS OF LOSS

BOILER & MACHINERY

DETAILS OF LOSS

EMPLOYEE DISHONESTY

NAME OF EMPLOYEE	DATE OF EMPLOYMENT
JOB TITLE	

ROBBERY OR SAFE BURGLARY

CULPRIT APPREHENDED-EXPLAIN

POLICE AUTHORITY INVOLVED EXPLAIN

ATTACH SUPPORTING MATERIAL-POLICE REPORT, NEWSPAPER ACCOUNT, DETAILS OF CLAIM, ETC

SUMMARY

SHOW LOSS OCCURRED AND DAMAGE EXTENT-ATTACH SUPPORTING MATERIAL ANY AVAILABLE REPORTS, NEWSPAPER ACCOUNT, PICTURES, REPAIR ESTIMATES OR BILLS ETC

_____ DATE

_____ SIGNATURE AND TITLE

GENERAL / PRODUCTS LIABILITY REPORT

Examples include:

- Injuries to individuals other than students occurring on school premises.
- Damages to non-school owned property

A copy of the General / Products Liability form is on the following page.

RESET FORM

Individual General/Products Liability Report Form

ACCIDENT REPORT – GENERAL/PRODUCTS LIABILITY

(DO NOT USE FOR AUTO)

NAME **DISTRICT:**			PHONE NUMBER	
ADDRESS	CITY		STATE	ZIP

ACCIDENT

DATE OF LOSS	TIME OF LOSS	LOCATION OF LOSS	CITY	STATE	ZIP

OFFICALS CALLED TO SCENE IF SO, IDENTIFY

☐ **POLICE** ☐ **FIRE DEPT.** ☐ **AMBULANCE**

CLAIMANT (PROPERTY DAMAGE)

NAME	ADDRESS	CITY	STATE	ZIP	PHONE

DESCRIBE DAMAGED PROPERTY	LOCATION OF PROPERTY	CITY	STATE	EXTENT OF DAMAGE

CLAIMANT (BODILY INJURY)

NAME	AGE	ADDRESS	CITY	STATE	ZIP	PHONE

OCCUPATION	DESCRIBE EXTENT OF INJURY

DESCRIPTION OF LOSS

WITNESS

NAME	ADDRESS	CITY	STATE	ZIP	PHONE
NAME	ADDRESS	CITY	STATE	ZIP	PHONE

IMPORTANT: HAS THIS ACCIDENT BEEN REPORTED TO OUR LOCAL EMERGENCY ADJUSTER? ☐ YES ☐ NO

IF REPORTED, NAME OF FIRM _____

ADDRESS _____

DATE ASSIGNED _____

_____ _____

DATE OF REPORT SIGNATURE AND TITLE

WINDSHIELD REPORT

For any school owned vehicle. Examples include:

- Bus
- Superintendent cars
- Pool cars
- Maintenance vehicles
- Contractor bus

A copy of the Windshield Only Report form is on the following page.

RESET FORM

Individual Windshield Report Form

WINDSHIELD ONLY

District Name				
Address	City	State	Zip	Phone
School/Dept. Name				
Address	City	State	Zip	Phone
Driver's Name				
Address	City	State	Zip	Phone

Date of Birth	Social Security No.	Driver's License No.

Vehicle

Make	Year	Model	Serial #	License #

Where Vehicle May be Seen	Used for Business? ☐ Yes ☐ No	Estimated Cost to Repair $

Accident

Date of Loss	Time of Loss	Location (Street/Highway)	City	State

Additional Comments:

IMPORTANT: Has this accident been reported to a CCMSI adjuster? Yes ☐ No ☐

If reported, name of adjuster _____

Signature/Title _____ Date _____

If you have any questions regarding claims reporting or management, please call:

Cannon Cochran Management Services, Inc.
4300 San Mateo NE, Suite A-300
Post Office Box 30870
Albuquerque, New Mexico 87190-0870

505-837-8700
800-635-0679