WORKERS COMPENSATION

Below are the steps to follow when an employee reports to you that they have been injured on the job. Paperwork will ask for a date and time.

1. Contact Suzanna George, HR Specialist at (505) 368-4984 ext. 10130 georsa@centralschools.org; Arielle John, HR-Benefits Specialist at (505) 368-4984 ext. 10126 johnar@centralschools.org; Marlena Harvey, HR Benefits Supervisor at (505) 368-4984 ext. 10124 harvm@centralschools.org.

2. Employee must complete the Workers Compensation (WC) packet as soon as possible. If the Date of Hire, Pay Rate or other pertinent employee information is unknown, HR will fill in the needed information once it is received. All documentation received in reference to a doctor's visit related to the injury must also be sent along with packet. Return the WC packet to HR for submission to Workers Comp-CCMSI.

3. School Administrator and/or Supervisor are ***required*** to complete the last two (2) pages of the packet.

4. Scan and email the completed packet to the HR contacts above. Originals can also be sent via District Interoffice Mail-Confidential.

- **No one can force the injured employee to seek medical care.**
- **No one is allowed to tell the injured employee what medical facility they must go to.**
- **The injured employee is required to complete the WC packet.**
- **Any on-the-job related injury must be reported, no matter how small.**
- **After submission to CCMSI, the employee will receive a WC claim number.**

Please do not hesitate to contact the HR WC team if you have any questions.

Thank you.

WORKERS COMPENSATION
BASIC INFORMATION

The Workers Compensation Act (WCA) requires a worker to report every accident to their supervisor within five (5) calendar days of its occurrence (reporting your accident to a co-worker is not considered proper notification). Although, the law allows up to five (5) day to report an accident or injury. Central Consolidated School District (CCSD) requires a 24-hour reporting timeframe.

The ***Employer's First Report of Injury or Illness, Supervisor's Accident Investigation Report, Supervisor's Workers Compensation Questionnaire*** forms must be completed by your **supervisor**.

The ***Notice of Accident or Occupational Disease Disablement*** needs to be completed by the **employee**. The information provided will be submitted electronically to CCMSI (CCSD's third party administrator for Workers Compensation). Delay in reporting your injury could hinder your WC process and/or benefits.

TAKE TIME TO PROVIDE THE NECESSARY DETAILS TO YOUR SUPERVISOR ALONG WITH YOUR PERSONAL INFORMATION TO COMPLETE THIS FORM.

If medical attention is required, CCSD allows the employee decide for themselves to seek medical treatment. CCSD and CCMSI retain the right to have the employee to seek a different physician after sixty (60) days, if necessary.

Call the employer the first day you miss work because of the injury. In order to receive salary benefits for lost time, we must have a doctor's note stating you will not return to work. The first seven (7) calendar days are NOT PAID by Workers Compensation (WC) and you will need to input your own leave. If you miss more than twenty-eight (28) days, WC will go back and pay for the first seven (7) days.

It is important to send any notes you receive from your doctor regarding your injury to Suzanna George to keep the Human Resources (HR) department and direct Supervisor informed.

If you are receiving disability benefits, you are required to report it to HR and your supervisor within twenty-four (24) hours. You are required to submit any written medical ***Release to Return to Work*** and/or physical limitations or work restrictions assessed by a physician. You are required to answer any reasonable requests by your Supervisor regarding your work status.

If you have any questions, please contact Suzanna George at (505) 368-4984 ext. 10130 or via email at: georsc@centralschools.org.

Print Name _____ Signature _____

Date _____

WORKERS COMPENSATION
PAYROLL RELEASE FORM

I, _____ authorize Central Consolidated School District (CCSD) to use my available sick leave and/or personal leave and/or vacation leave while on Workers Compensation (WC) leave.

I understand that any Workers Compensation payments made to me while receiving a payroll check from CCSD will be docked from my regular pay to reimburse my leave.

I understand that in the event all of my sick leave and/or personal leave and/or vacation leave is exhausted, I will receive only the Workers Compensation checks.

_____ _____

Signature Date

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

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)
Central Consolidated School District
P. O. Box 1199
Shiprock, NM 87420

PHONE NUMBER: 505-368-4984
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:

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

AGENT NAME & CODE NUMBER:

EMPLOYEE

NAME (LAST, FIRST, MIDDLE):
DATE OF BIRTH:
SOCIAL SECURITY NUMBER:
DATE HIRED:
STATE OF HIRE:

ADDRESS (INCL ZIP):

GENDER: ☐ MALE ☐ FEMALE ☐ UNKNOWN

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

OCCUPATION/JOB TITLE OR (SOC) CODE:
EMPLOYMENT STATUS:
NCCI CLASS CODE:

PHONE NUMBER:
OF DEPENDENTS:

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.

SUPERVISOR'S ACCIDENT INVESTIGATON REPORT

GENERAL INFORMATION	DEPARTMENT		SHIFT
	EMPLOYEMPLOYEE NAME		JOB TITLE
	EMPLOYEMPLOYEE NUMBER		SEX MALE FEMALE
	TYPE OF ACCIDENT/ILLNESS		
	TYPE OF INJURY		
	PART OF BODY INJURED	TREATMENT FIRST AID MEDICAL	DID EMPLOYEMPLOYEE RETURN TO WORK THE SAME DAY? YES NO
DESCRIPTION	WHERE DID THE ACCIDENT HAPPEN? USE ADDITIONAL SHEMPLOYEETS IF NECESSARY.		
CAUSES	SPECIFIC MACHINE, TOOL, SUBSTANCE OR OBJECT CONNECTED WITH THE ACCIDENT		
	UNSAFE MECHANICAL/PHYSICAL/ENVIRONMENTAL CONDITION AT TIEM OF ACCIDENT (Be Specific)		
	PERSONAL FACTORS (Attitude, Lack of Knowledge or Skill, Slow Reaction, Fatigue)		
	PERSONAL PROTECTICE EQUIPMENT REQUIRED		
	WAS INJURED EMPLOYEMPLOYEE USING REQUIRED EQUIPMENT?		
RECOMMENDATIONS	ACTION PLAN TO PREVENT REOCCURANCE (Modification of Machine, Mechanical Guarding, Environment, Training) **SUPERVISOR'S SIGNATURE** _____ **DATE** _____		
FOLLOW UP	ACTIONS TAKEN ON RECOMMENDATIONS (Include Date Completed)		

Supervisor's Workers Compensation Questionnaire

1. Do you have any questions or concerns regarding the injury?

2. When did the employee report the injury to their supervisor?

3. Who did the employee report it to first?

4. Has the employee lost any time from work? If yes, give dates.

5. Is the employee on light or modified duty? If yes, can CCSD accommodate these duty restrictions? The employee must submit an accommodation request to HR.

6. Does the employee plan to seek medical care? If yes, which medical provider has the employee identified they will seek initial medical treatment from?

7. Is there surveillance camera in the area of the alleged incident? If yes, please retain a copy in case it is required at a later date.

Payroll: Provide payroll records for the twenty-six (26) weeks before the date of the injury or provide wage contract. If the worker's hire date is less than twenty-six (26) weeks, please provide wages from the date of hire.

HR: Provide a copy of the employee's Job Description.