CENTRAL CONSOLIDATED SCHOOL DISTRICT #67
P.O Box 1199
Shiprock, NM 87420

In case of a work place injury:

WORKER GRAB 'N GO KIT

EMPLOYEE INSTRUCTIONS:

This Worker Grab-N-Go Kit is designed to facilitate the Workers' Compensation process in the event of a workplace injury. The documents listed below are contained in this Grab 'N Go kit. This envelope and its contents should be completed to its entirety; signed and dated by the injured worker/supervisor. Please review all contents and follow the directions written next to each document listed.

Documents 1 – 5: Must be completed by the injured worker/supervisor.

- ☐ 1. **Notice of Accident or Occupational Disease Disablement form (NOA-2)** – Completed & signed by both worker & supervisor.
- ☐ 2. **Employers' First Report of Injury or Illness** – Complete all sections with specific details. (Employee/Supervisor)
- ☐ 3. **Workers Compensation Basic Information** – To be read, signed and dated. (Employee)
- ☐ 4. **Workers Compensation Payroll Release Form** – To be read, signed, and acknowledged. (Employee)
- ☐ 5. **Workers Authorization for Use & Disclosure of Health Records** (Employee)

Documents 6 – 7: Must be completed by your Supervisor:

- ☐ 6. **Supervisor's Incident Investigation Report** – Must be completed to its entirety; signed and dated by supervisor.
- ☐ 7. **Supervisor's Workers Compensation Questionnaire** – Must be completed to its entirety; signed and dated by supervisor.

Document 8: Must be completed by your treating health care provider (physician) at your initial visit and at each follow-up appointment. Return documents to HR two (2) days prior to your return to work or after each one of your appointments.

- ☐ 8. **Provider's Report of Physical Ability** - Must be completed by Health Care Provider treating physician with complete clarification regarding employee return to work status; signed and dated.

For questions or assistance, please contact Suzanna George (CCSD Workers Comp designee) at (505) 515-0439 or email: georsc@centralschools.org or you may contact the HR Benefits office at (505) 598-1018.

Please return all above documents to our CCSD Workers Compensation designee.

Thank you for cooperating with our efforts to maintain a safe, healthy and productive work environment for all of CCSD employees.

CENTRAL CONSOLIDATED SCHOOL DISTRICT
CCSD Administration Complex • Human Resources Benefits Office
P.O Box 1199 Shiprock, NM 87420 * US Hwy 64, Old High School Rd
Phone: (505) 598-1018 * Fax: (505) 515-0439 or (505) 521-6329

WORKERS COMPENSATION CHECKLIST

What to do when if you are injured on the job?
If you suffered a workplace injury, accident, or illness, you may be eligible for Workers' Compensation benefits. You must immediately notify your supervisor and HR. Complete the Workers Compensation (WC) packet as soon as possible and submit to the HR Benefits Office. Seek medical treatment if necessary.

Complete the following forms:

- ☐ Notice of Accident form (NOA-2) **(page 1 – completed by injured employee w/ Supervisor signature/date)**
- ☐ Employer's First Report of Injury or Illness **(page 2 - Employee/Supervisor)**
- ☐ Workers Compensation Basic Information form **(page 3 - Employee)**
- ☐ Workers Compensation Payroll Release form **(page 4 – Employee)**
- ☐ Workers Authorization for Use & Disclosure of Health Records **(page 5 - Employee)**
- ☐ Supervisor Incident Investigation Report **(page 6 - Supervisor)**
- ☐ Supervisor's Workers Compensation Questionnaire **(page 7 - Supervisor)**
- ☐ Provider's Report of Physical Ability to be completed by Health Care Provider & Prescription **(page 8 - Health Care Provider)**

EMERGENCY SITUATIONS:

1. **CALL 911 (nurse, supervisor or appropriate site personnel). CCSD employees should NOT transport the injured worker.**
2. Seek medical treatment at any medical facility of your choosing which accepts NM Workers compensation insurance. **CCSD cannot recommend direct care.**
3. Notify medical personnel it is a WC injury. Do not use personal insurance.

NON-EMERGENCY or DURING REGULAR BUSINESS HOUR SITUATIONS:

1. You *may* seek medical treatment at any medical facility of your choosing which accepts NM Workers Compensation insurance. **CCSD cannot recommend direct care**.
2. Notify medical personnel it is WC injury. Do not use personal insurance.

** Submit to your Supervisor and to the HR Benefits office with a physician note, explaining medical status and/or work restrictions prior to your return to work. These documents must be given to HR upon receipt.

IMPORTANT CONTACT INFORMATION:

Suzanna George Specialist, HR (505) 515-0439 (505) 368-4984 ext. 10130 georgs@centralschools.org	Arielle John Specialist, HR-Benefits Office (505) 521-6355 (505) 368-4984 ext. 10126 Work mobile: (505) 629-8161 johnar@centralschools.org	Marlena Harvey Supervisor, HR Benefits (505) 521-6329 Work Mobile (505) 419-9212 harvm@centralschools.org

CCMSI, WC Claims Administrator:
505-837-8700 or
800-635-0679

The NM Workers' Compensation Administration, Ombudsman program:
866-967-5667

RESET FORM

NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACIÓN DE ACCIDENTE O ENFERMEDAD DE OFICIO

In accordance with New Mexico law, Section 52-1-29, Section 52-3-19 and Section 52-1-49, NMSA 1978; NMAC 11.4.4.11
Conforme a la Ley de la Compensación de los Trabajadores, Sección 52-1-29 ,Sección 52-3-19 y Sección 52-1-49, NMSA 1978; NMAC 11.4.4.11

I, _____ was involved in an on-the-job accident or was disabled by an occupational disease
Yo, (name of employee/*nombre del empleado)* *me lastimé en un accidente en el trabajo o fui incapacitado por enfermedad de oficio*

at approximately _____,on _____, 20___. Date of Hire _____ Employee's Date of Birth _____
proximadamente (time/*a la(s) hora(s)*) *el* (date/*fecha)* (*del 20___.)* (*fecha de empleo*) (*fecha de nacimiento*)

Employee's social security number: _____ Employee's Home Address: _____
Número de seguro social del empleado: *Direccion del empleado*

Employee's Telephone Number(s): Home: _____ Mobile: _____ Other: _____
Número de teléfono(s): (*Casa*) (*Celular*) (*Otro*)

Where did the accident occur? _____
¿Dónde ocurrió el accidente?

What happened?_____
¿Qué ocurrió?

_____

_____

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

CENTRAL CONSOLIDATED SCHOOL DISTRICT
Internal Workers Compensation First Report of Injury

EMPLOYER:	CONTACT:	CARRIER / FEIN: 850365634	CLAIMS ADMINISTRATOR:
CCSD Administration Complex Human Resources Department P.O. BOX 1199 Shiprock, NM 87420 505-598-1018	Suzanna George Specialist, Human Resources Direct: (505) 515-0439 Email: geors@centralschools.org	NMPSIA (New Mexico Public Ins. Authority) 410 Old Taos Hwy. Santa Fe, NM 87501	CCMSI (Cannon Cochran Management Services Inc.) P.O. Box 30980 Albuquerque, NM 97190-0870 Tel 505-837-8700 / 1-800-635-0679

OCCURANCE OF INCIDENT AND WORK DATES

Date of Incident:		*Time Incident Occurred:*		*Date Last Worked:*		*Date Returned to Work:*	

SPECIFIC LOCATION OF INCIDENT (School Name, Building, Room Number, hallway, etc.)	**DATE FIRST REPORTED TO EMPLOYER** (MM/DD/YYYY)

Is there video surveillance of the incident? If so, please save and send to HR Contact. YES ☐ NO ☐
(Describe Injured Employee (hair color, glasses, color of shirt, and/or something that would identify them in the video)

INJURED EMPLOYEE NAME			**DATE OF BIRTH** (MM/DD/YYYY)	**SOCIAL SECURITY NUMBER** (Full/Complete SSN)	**GENDER AT BIRTH**
Last	***First***	***Middle***			☐ Male ☐ Female

Work Email & Phone Number	**Personal Email & Phone Number**	**Preferred Language:**

INJURED EMPLOYEE MAILING ADDRESS	**JOB TITLE**	**DATE OF HIRE** (MM/DD/YYYY)

WAGES/SALARY | $_____	**EMPLOYMENT STATUS**
☐ Hourly ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually	☐ Full-Time ☐ Part Time ☐ Hourly ☐ Other

EMERGENCY CONTACT FOR INJURED EMPLOYEE

Name		*Address*		*Phone*	

ACCIDENT DESCRIPTION:
- Included Notice of Accident (NOA) with this form. If NOA is illegible or non-English, provide legible English version here.

PART(S) OF BODY AFFECTED/ SYMPTOMS:	**TYPE OF ACCIDENT** (e.g. Fall, Strain, etc.)

TREATMENT RECEIVED *OR* PLAN TO RECEIVE

☐ **None** ☐ **First Aid Only (by self, staff nurse, etc.)** ☐ **Physician/Health Care Provider** ☐ **Hospital** ☐ **Emergency Room/Urgent Care** ☐ **Transported**

PREPARER'S NAME AND PHONE NUMBER	**DATE SUPERVISOR or ADMINISTRATOR NOTIFIED** (MM/DD/YYYY)
EMPLOYEE'S SIGNATURE AND DATE	**SUPERVISOR or ADMINISTRATOR SIGNATURE AND DATE**

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Phone: (505) 598-1018 * Fax: (505) 515-0439 or (505) 521-6329

WORKERS COMPENSATION BASIC INFORMATION

- The Workers Compensation Act (WCA) requires a worker to report every accident to their supervisor and the Human Resources Benefits Department within 15 calendar days of its occurrence. Central Consolidated School District (CCSD) requires a 24-hour reporting timeframe from the time of incident.
- The ***Notice of Accident or Occupational Disease Disablement (NOA-2), First Report of Injury, Payroll Release form, Authorization for Use & Disclosure of Health Records*** needs to be completed by the **employee.**
- The ***Employer's First Report of Injury or Illness, Supervisor's Accident Investigation Report, Supervisors Worker's Compensation Questionnaire*** *forms must be completed by your* ***supervisor***.
- All reporting forms will be submitted electronically to CCMSI (CCSD's third party administrator for Workers Compensation). Delay in reporting your injury will 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.**
- Call your supervisor the first day you miss work because of the injury. In order to receive salary benefits for lost time, HR 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 that you have available. 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 keep the Human Resources Benefits department and your 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 the Human Resources Benefits Department at (505) 368-4984 or (505) 598-1018.

I have fully read and acknowledged the basic information stated forth.

X _____
Signature

X _____
Print Name

Dated: _____

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Limited Use of Paid or Unpaid Leave for a Work-Related Injury & CCSD Payroll Release Form

Lost Wages Benefits (indemnity payments) The Worker's Compensation Administration provides benefits (calculated in accordance with state laws) to an employee for a portion of the time the employee is absent from the job due to work-related injury or illness.

The first seven (7) days (consecutive or nonconsecutive) of disability is considered to be the waiting period when no indemnity benefits are due, and must be charged to available leave (sick leave, paid leave, vacation leave or Leave Without Pay). After the seven (7) day waiting period, the worker may be entitled to workers' compensation indemnity benefits at an amount equal to 66 2/3% of the worker's average weekly wage or up to the statutory maximum allowed at the time of injury.

If the period of disablement extends past twenty-eight (28) days, Workers' Compensation will then pay the employee indemnity benefits for the first seven (7) days of the disablement if the worker used their available leave. If this occurs then the worker is required to notify CCSD to endorse the check to the employer for the seven days.

Payment of Insurance Premiums

In order to allow the worker to maintain other employment benefits such as annuities, supplemental benefits, and health insurance premiums for family members and dependents, the worker is permitted to use leave (sick, paid, vacation leave) in addition to worker's compensation indemnity benefits to equate to 100% of the worker's gross wage. The worker will not be paid in excess of 100% of gross wage when both Leave (sick, paid, or vacation) and compensation are combined. The worker will not be entitled or permitted to any advance or additional paid sick leave that the work might potentially accrue during the balance of the fiscal year.

When an employee is absent due to a work-related occurrence and is not receiving wages from CCSD, the employee must pay his/her portion of the premiums directly to CCSD. CCSD will continue to pay the employer share through the end of the current fiscal year or for as long as the employee continues to pay their premium share.

Family and Medical Leave Act (FMLA) benefits will run concurrently with employee's time off for a work-related injury. If employee is eligible for FMLA. **All leave will run concurrently with FMLA.**

Please read the following carefully and initial next to each line.

_____ I understand while I am on Workers Compensation (WC) leave I will use my accrued sick leave and/or paid leave and/or vacation leave during the first (7) days of disability. I understand that if my leave of absence due to my WC injury extends past (7) days and I am unable to resume work, my pay will be stopped to be restarted once I am released to return to work with or with no restrictions.

_____ I further understand, in the event of my sick leave, paid leave, or vacation leave have been exhausted, I will use Leave Without Pay (LWOP).

_____ 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 that all my sick leave and/or paid leave and/or vacation leave is exhausted, I will receive only the Workers Compensation checks.

_____ If my Workers Compensation Injury/illness exceeds 28 days leave of absence, I agree to reimburse CCSD for any amount that is greater than 100% of my weekly gross wage due to use of District leave benefits and duplicated payment of Worker's Compensation benefit for the first seven (7) days of the disability.

Signature X _____ Date: _____

Print Name X _____

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS

Worker/Patient FULL NAME: _____ DOB: _____ SSN: XXX-XX-_____

FOR WCA REFERENCE ONLY: Date/s of Injury: _____ WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with Section 52-10-1 NMSA 1978, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any workplace injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed $1.00 per page for the first ten (10) pages or up to twenty-cents ($0.20) for each page thereafter. A copy of this authorization may be used as an original.

Este formulario es obligatorio al presentar una queja. Si necesita ayuda para completar este formulario, póngase en contacto con un ombudsman (866) 967-5667.

RELEASE OF HEALTH CARE RECORDS

I, (Worker's Name) _____, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility:		
Address:		
Telephone No.:		

I authorize the following records released (check box, as appropriate): ☐ **ALL RECORDS** ☐ **SPECIFIC DATES**

provide a date range for records authorized to be released _____

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (check any that may apply).

☐ Treatment for alcohol and/or substance abuse ☐ Sexually transmitted diseases ☐ HIV or AIDS

☐ Behavioral or Mental Health, including Psychiatric or Psychological ☐ Records of the Department of Health Medical Cannabis Program

_____ _____

Signature of Worker/Patient/Personal Representative Date

PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be _X_ Picked Up _X_ Mailed _X_ Emailed _X_ Faxed _X_ Other (specify): _____

Authorized Recipient/s:	CCMSI	
Address:	PO BOX 30870	Central Consolidated School District
	ALBUQUERQUE, NM 87190-0870	SHIPROCK, NM 87420
Telephone No.:	505-837-8700	Phone/Fax: 505-515-0439, 505-521-6329, or 505-521-6355
Fax/Email:	505-888-6794	

EXPIRATION and CONDITIONS

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

_____ _____

Signature of Worker/Patient Date

_____ _____

Signature of Personal Representative (if any) Date

_____ _____

Printed Name of Personal Representative Relationship to Worker/Patient

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

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 ☐ FIRST AID ☐ MEDICAL	DID EMPLOYEE RETURN TO WORK THE SAME DAY? ☐ 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)		

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Supervisor's Workers Compensation Questionnaire

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

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

3. 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

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

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.

WORKERS' COMPENSATION ADMINISTRATION

PROVIDER'S REPORT OF PHYSICAL ABILITY

This form shall be reimbursed **if completed at initial visit or for a change in work status or activity restrictions**, per WCA Health Care Provider Fee Schedule p. 22. Helpful guidelines on back

1 - GENERAL INFORMATION

1 GENERAL INFORMATION

Worker Name (Last, First)		**Date of Injury**	**Visit date**	**Facility Address and Phone**
SSN-last 4 digits XXX-XX-	**Date of Birth**	**Primary Treating Provider Name**		

Visit Type: ☐Initial ☐Follow-up - **For follow-ups, is there a change in your recommendation since last visit?** ☐YES ☐NO

Diagnosis: _____

In my opinion, this diagnosis is: ☐Work-related ☐Not work-related

Maximum Medical Improvement (MMI) indications (Check one and indicate date) :

☐Worker reached MMI on_____(date). ☐ Not at MMI but anticipated on _____ (date).

2 - WORK STATUS

2 WORK STATUS

After evaluation, I recommend this worker be (check only one option) :

☐ **OPTION 1 – Released to regular work** Status from (start date):_____ to (end date):_____

Released to hours and tasks routinely performed on the job held at the time of injury. SKIP TO SECTION 4 FOLLOW-UP

☐ **OPTION 2 – Not released to ANY work at all** Status from (start date):_____ to (end date):_____

The worker is not capable of performing ANY work activities at this time. SKIP TO SECTION 4 FOLLOW-UP

☐ **OPTION 3 – Released to modified duty** Status from (start date):_____ to (end date):_____

Released to work, **subject to the following restrictions in Section 3 ACTIVITY RESTRICTIONS** (Unmarked items indicate no restriction)

3 - ACTIVITY RESTRICTIONS

3 ACTIVITY RESTRICTIONS

Lift / Carry / Push / Pull Restrictions (if any)

Maximum cumulative hours/day →		**0**	**2**	**4**	**6**	**8**	**Other**
Lift from the floor	☐**Left** ☐**Right**	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____
Lift from waist height	☐**Left** ☐**Right**	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____
Carry	☐**Left** ☐**Right**	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____
Push	☐**Left** ☐**Right**	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____
Pull	☐**Left** ☐**Right**	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____

Posture / Motion Restrictions (if any)

Maximum cumulative hours/day →		**0**	**2**	**4**	**6**	**8**	**Other**
Stand		☐	☐	☐	☐	☐	
Walk		☐	☐	☐	☐	☐	
Sit		☐	☐	☐	☐	☐	
Bend / Stoop		☐	☐	☐	☐	☐	
Twist		☐	☐	☐	☐	☐	
Kneel / Squat		☐	☐	☐	☐	☐	
Climb (stairs/ladder)		☐	☐	☐	☐	☐	
Drive		☐	☐	☐	☐	☐	
Grasp / Squeeze	☐**Left** ☐**Right**	☐	☐	☐	☐	☐	
Wrist (flex/extension)	☐**Left** ☐**Right**	☐	☐	☐	☐	☐	
Fine manipulation	☐**Left** ☐**Right**	☐	☐	☐	☐	☐	
Reach above shoulder	☐**Left** ☐**Right**	☐	☐	☐	☐	☐	
Reach below shoulder	☐**Left** ☐**Right**	☐	☐	☐	☐	☐	
Other:		☐	☐	☐	☐	☐	

Miscellaneous Restrictions (if any)

☐ Max hours per day of work: _____

☐ Sit/stretch breaks of _____(# of times) per _____

Medication Restrictions (if any)

☐ Meds restrict ability to work safely (explain restrictions below)

Psychological Restrictions (if any)

☐ Psychological restrictions evident (explain restrictions below)

OTHER RESTRICTIONS / MODIFICATIONS (be specific) :

4 - FOLLOW-UP

4 FOLLOW-UP

Expected follow-up services (check all that apply and indicate dates, if known) :

Clear Form

☐ Next evaluation by treating provider on _____ (date) at _____ (time)

☐ Referral to / Consult with _____ (provider name and specialty)

☐ Physical / Occupational therapy / Chiropractic / Osteopathic Rehabilitation / Reconditioning _____ x/week for _____ weeks

☐ Other treatment / Follow-up _____

☐ Worker fully discharged from care. This is the last scheduled visit for this problem.

Provider Signature: _____ Date this form completed:_____

WCA PROVIDER'S REPORT OF PHYSICAL ABILITY (back page)

HELPFUL GUIDELINES / DEFINITIONS FOR HEALTH CARE PROVIDER (HCP) COMPLETING THIS FORM

BASIC INFORMATION:

- **For questions on this form:** Email the WCA Medical Cost Containment Bureau at WCA-MCC@state.nm.us or call 505-841-6042**.**
- **Purpose of this form:** Because a prolonged workplace absence is detrimental to a worker's well-being, the WCA asks that you facilitate the recovering worker's safe, efficient return-to-work by providing interested parties a clear, quantitative description of current claim-related physical restrictions. In this way, you help employers identify suitable work and assign safe work activities.
- **When / who fills this form out:** Based on a reasonable medical probability, you as the primary treating HCP are encouraged to fill this form out at each appointment, however **you can only be reimbursed if the form is completed at the initial assessment or if there is a change in work status or activity restrictions**, as indicated in the WCA Health Care Provider fee Schedule and Billing Instructions (HCP Fee Schedule).
- **After you fill this report out:** Provide a copy to the worker immediately after each office visit.
- Note- This form is not intended to substitute a Functional Capacity Evaluation (FCE).

DEFINITIONS OF PHYSICAL CAPACITY LEVELS (for reference only):

Sedentary - Ability to lift up to 10 lbs. occasionally or 5 lbs. frequently with sitting, walking/standing necessary to carry out duties
Light - Ability to lift up to 20 lbs. occasionally or 10 lbs. frequently, significant standing/walking or sitting with pushing/pulling of arm/leg
Medium - Ability to lift up to 50 lbs. occasionally or up to 25 lbs. frequently
Heavy - Ability to lift up to 50 lbs. occasionally or up to 50 lbs. frequently

HELPFUL GUIDELINES:

1 - GENERAL INFORMATION Fill out worker's name, last 4 digits of SSN, date of birth, date of injury, visit date, your clinic or facility name and address, your name as the primary treating HCP and your phone number

a. Visit Type: Indicate if this is an initial or follow-up visit for this worker regarding this workers' compensation injury/illness
b. For Follow-ups only: Check either YES or NO to indicate if you are making ANY change in recommendation since the last visit
c. Diagnosis: Indicate diagnosis. Underneath, check if, in your opinion the diagnosis is work-related or not work-related. Check only one box
d. Maximum medical improvement (MMI) –Check only one box. Indicate the date if the worker has reached MMI at the current visit or at a prior visit. If worker is not at MMI yet, write the date you anticipate the worker might reach MMI

2 - WORK STATUS Check the appropriate option box to indicate if the medical condition(s) resulting from this workers' compensation injury/illness will allow for this worker to return-to-work in some capacity. For each option, indicate the start and anticipated end date of your current work status recommendation. If it is permanent, you can write that in. Note: DO NOT check more than one box.

a. Option 1 - Check this box to release the worker to regular work with no restrictions. Do not fill out Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 FOLLOW-UP and sign/date
b. Option 2 - Check this box if you recommend NO work at all be performed at this time. Do not fill out Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 FOLLOW-UP and sign/date
c. Option 3 - Check this box if you feel the worker can return to work in a modified duty capacity with restrictions. Fill out Section 3 ACTIVITY RESTRICTIONS to indicate all the applicable restrictions as well as Section 4 FOLLOW-UP and sign/date

3 - ACTIVITY RESTRICTIONS Fill this section out only if you checked "Option 3 – Released to modified duty" in Section 2 WORK STATUS

- These restrictions are based on the HCP's best understanding of the employee's essential job functions
- If a particular restriction does not apply, leave it blank. All unmarked items are considered no restrictions
- Note to worker : These restrictions should be followed outside of work as well as at work

a. Lift / Carry / Push / Pull Restrictions: For each activity listed that you are restricting -
a1. Check "Left or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"
a2. Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle
a3. Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate
– Note re lifting restrictions: If you are restricting lifting from the floor, indicate If lifting from waist height is also restricted
b. Posture / Motion Restrictions: For each activity listed that you are restricting -
b1. Where applicable, check "Left or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"
b2. Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle
b3. Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate
c. Miscellaneous Restrictions: Check all restrictions that may apply and write in applicable specifics
d. Medication Restrictions: Check if medication(s) restrict work ability. Explain restrictions under "Other restrictions/modifications"
e. Psychological Restrictions: Check if psychological factors restrict work ability. Explain under "Other restrictions/modifications"
f. Other Restrictions / Modifications: If your recommendations are not indicated anywhere else on this form, write in

4 - FOLLOW-UP Fill this section out at each appointment to indicate ongoing treatment / follow-up services / referrals you are recommending. Check all that apply and indicate dates, if known

a. Next evaluation: Provide the date of the next scheduled appointment the worker has with you as the treating provider
b. Referral to / Consult with: If you are referring the worker to a specialist or other HCP, write in the HCP name and specialty
c. Physical / Occupational Therapy: Circle appropriate treatment and indicate how many times per week worker should attend
d. Other Treatment / Follow-up: Check if applicable. Write in any other treatment and/or follow-up you are recommending
e. Worker fully discharged: Check only if you are discharging the worker from any further care for this particular condition

Optum
PO Box 152539
Tampa, FL 33684-2539

MAKING IT EASY...

TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM® Comp MC Rx

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

CARRIER/TPA EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP			

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

The following entities comprise the Optum Workers Compensation and Auto No Fault division: PMSI, LLC, dba Optum Workers Compensation Services of Florida; Progressive Medical, LLC, dba Optum Workers Compensation Services of Ohio; Cypress Care, Inc. dba Optum Workers Compensation Services of Georgia; Healthcare Solutions, Inc., dba Optum Healthcare Solutions of Georgia; Settlement Solutions, LLC, dba Optum Settlement Solutions; Procura Management, Inc., dba Optum Managed Care Services; Modern Medical, dba Optum Workers Compensation Medical Services, collectively and individually referred as "Optum."

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