New Mexico Workers' Compensation Administration Bulletin

Special Edition

Employers are required to post the workers' compensation poster with the Notice of Accident Forms at their workplaces.

The Workers' Compensation Administration asks all insurers and self-insurance administrators to educate employers so that they comply correctly with the posting requirement.

Employers should be advised to:

- Display the poster properly at all work sites;
- Post **Notice of Accident (NOA)** forms with the poster;
- Educate their employees on the use of the NOA forms.
- The poster has a blank space in which the employer is required to write the name of the employer's insurance carrier or self-insurance program, along with a contact telephone number.
- The contacts must be located in New Mexico as required by law.
- Employers are required to hang or post a supply of NOA forms attached to the poster. The forms can be hung at the bottom where indicated.

Complying with the law:

- If the poster is displayed without the forms attached or adjacent, that does not comply with the law.
- Employers must give workers access to the two-part carbonless Notice of Accident form or a printed copy that can be downloaded from the WCA website.
- When a worker uses the form to report an accident, the employer is required to accept the form as the worker's official notice, to sign and date the form and give the worker a copy.

Where to get posters and forms:

The WCA poster and NOA are available on the WCA web site:
www.workerscomp.state.nm.us

Go to any WCA office in person; for large quantities, please telephone ahead.

To request and receive printed copies of the poster and /or Notice of Accident forms by mail, contact the Publications Office at:

Call: (505) 841-6000 or, 1-800-255-7965, or email request to: wca.hotline@state.nm.us

These materials are free of charge. For large quantities, you will be asked to pay mailing costs.

WCA HELPLINE - HOTLINE:
(toll free in New Mexico)

1-866-WORKOMP **1-866-967-5667**

www.workerscomp.state.nm.us

What is the poster for and why are employers required to post it?

The purpose of the workers' compensation poster is:

- to inform workers that their employer has workers' compensation insurance (or self-insurance) coverage, and that they have certain rights if they are injured;
- to provide a way for workers to notify their employers in writing if they have an accident, with a copy that the worker may keep for his or her own records.

By law, employers must allow their employees to report accidents in writing using the NOA forms. It is not legal for employers to require employees to report by another method, unless the employer has received approval from the Director of the WCA.

The intention of the law is for workers to have free access to the forms. If the worker has to ask the supervisor for a form to fill out, that is contrary to the purpose of the law.

When does a worker NOT have to use an NOA form?

- If the employer (or someone in authority, such as a supervisor) had "actual notice" of the accident. Usually this means the employer or supervisor was present and witnessed the accident.
- If the worker is prevented from giving notice by circumstances beyond the worker's control. In such case, the worker must give notice within 60 days.

What is the consequence if an employer does not post the poster?

The right of the injured worker to notify the employer and make a claim is extended from 15 days to 60 days.

This is considered to be a disadvantage for the employer, especially if there is any question about whether the claim was valid. It is very hard to investigate an accident 60 days after it happened.

This Special Edition WCA Bulletin is published by the Public Information Office of the New Mexico Workers' Compensation Administration.

Frequently asked questions:

May employers print their own posters?
If privately printed posters are exact copies of the WCA poster, and are provided to employers by insurers free of charge, that is acceptable.

How long will the current poster last?
The current poster is valid until it is rescinded by order of the Director, a change in the rules, or a change in the law. The previous poster was in use for 11 years.

What if employers want to put the poster into a frame so that there will be a neat display?
That is OK as long as NOA forms are placed near the poster and are accessible to workers.

What about the poster that employers can buy from commercial companies?

- It is not necessary for employers to buy commercial posters.
- Commercially purchased posters are acceptable by law if they are identical to the WCA poster.
- Commercial vendors normally do not provide NOA forms to employers along with the mandatory posters. If the employer does not post NOA forms, it does not comply with the law.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION OFFICES

Albuquerque Headquarters:
2410 Centre Ave. SE Albuquerque, NM 87106
Phone: (505) 841-6000 toll-free: 1-800-255-7965

Regional Field Offices:
Farmington:
2700 Farmington Ave., Bldg. E, Ste. 2 Farmington, NM 87401
Phone: (505) 599-9746 toll-free: 1-800-568-7310

Las Cruces:
1120 Commerce Dr, Suite B-1 Las Cruces, NM 88011
Phone: (575) 524-6246 toll-free: 1-800-870-6826

Las Vegas:
32 NM 65 Las Vegas, NM 87701
Phone: (505) 454-9251toll-free: 1-800-281-7889

Lovington:
100 West Central, Suite A Lovington, NM 88260
Phone: (575) 396-3437 toll-free: 1-800-934-2450

Roswell:
Penn Plaza Building, 400N. Pennsylvania Ave., Ste. 425
Roswell, NM 88201 (575) 623-3997 toll-free: 1-866-311-8587

Santa Fe:
Aspen Plaza Building, 1596 Pacheco St., Suite 202
Santa Fe, NM 87505 Phone: (505) 476-7381

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 él 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	1-800-568-7310	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	1-505-454-9251	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 3/15/07. It remains valid until reissued and supersedes all prior versions except 3/15/03.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

EMPLOYERS' FIRST REPORT OF INJURY OR ILLNESS

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

OFFICIAL USE ONLY

PLEASE PRINT IN BLACK INK OR TYPE.

GENERAL

EMPLOYER (NAME & ADDRESS INCL ZIP)

PHONE NUMBER

EMPLOYER FEIN

CARRIER / ADMINISTRATOR CLAIM #

OSHA LOG NUMBER

REPORT PURPOSE CODE

JURISDICTION

JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)

LOCATION #

INDUSTRY CODE

CARRIER

CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)

POLICY PERIOD

TO

CHECK IF APPROPRIATE
☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)

CARRIER FEIN

POLICY / SELF-INSURED NUMBER

ADMINISTRATOR FEIN

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

PHONE NUMBER

OF DEPENDENTS

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.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION

ALBUQUERQUE Phone: (505) 841-6000 **In-State Toll Free: 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

FILING INSTRUCTIONS

PURPOSE: To report all alleged work-related injuries or illnesses resulting in more than 7 days of lost work or in death of the worker. This form is not an admission or denial by the employer as to whether the worker's alleged injury or illness is compensable, **and must be completed by the employer or the employer's representative.**

WHEN TO FILE: This form must be filed within 10 days of knowledge of any alleged work-related injury or illness that results in more than 7 days of lost work. **It must be filed even if the employer disputes the worker's claim of work-related injury or illness.**

WHERE TO FILE: Mail the original form to the New Mexico Workers' Compensation Administration (Attention: Statistics) at the address on the front of this form. **Copies must also be provided to the worker and the employer's workers' compensation insurer.**

PENALTIES: Each instance of failure to file this form when required is punishable by a fine of up to $1,000.00.

INSTRUCTIONS FOR COMPLETION

FILLING IN THE SHADED AREAS IS OPTIONAL. The employer may wish, however, to use some of these areas (such as "Witnesses") for the employer's records. Expanded instructions are found in the publication ***Guide to Completing the Employer's First Report of Injury or Illness***, available from the Administration's Albuquerque office (call either number bold-faced above and ask for Statistics).

Please print in black ink or type, and ensure that all entries are legible before submission. An illegible or incomplete E1 may be returned.

NAIC CODE: Represents the nature of the employer's business at the location where the worker was employed at the time of injury or illness exposure; derived from the federal government publication *North American Industry Classification System Manual*. Include this code if known.

EMPLOYER'S LOCATION ADDRESS: Facility where the worker was employed at the time of injury, if different from mailing address.

CARRIER: Name, mailing address and telephone number of the licensed business entity issuing a contract of insurance and assuming financial responsibility on behalf of the employer. A WCA-approved self-insured employer should enter its business name.

CLAIMS ADMINISTRATOR: Name, mailing address and telephone number of the insurance carrier, agency, third party administrator or self-insured responsible for adjusting the claim.

EMPLOYER, CARRIER OR ADMINISTRATOR FEIN: Federal Identification Number, assigned by the Internal Revenue Service.

DID SALARY CONTINUE? Shows if the employer is continuing to pay the worker's regular wages *without charge to employee benefits.*

DATE OF INJURY/ILLNESS: In the case of an occupational illness (arising from the worker's activity or exposure over an extended period), enter the date of diagnosis or the date first reported to the employer as possibly work-related.

DATE EMPLOYER NOTIFIED: The date the worker first notified (verbally or in writing) the employer or the employer's representative of the alleged work-related injury or illness.

DATE DISABILITY BEGAN: The first full day on which the worker lost time from work due to the injury or illness.

TYPE OF INJURY OR ILLNESS: Briefly describe the nature of the injury (such as lacerations to the forearm) or illness (such as carpal tunnel syndrome). Be as specific as possible.

PART OF BODY AFFECTED: The specific part of body affected by the injury or illness (for example, right forearm, lower back).

DEPARTMENT OR LOCATION: If the accident or illness exposure did not occur on the employer's premises, enter specific address or location (for example, Client's office at 123 Main St., Yourtown, NM 87xxx). For occurrences in New Mexico, give ZIP or COUNTY.

ALL EQUIPMENT, MATERIAL OR CHEMICALS: List all equipment, materials and/or chemicals the worker was using, applying, handling or operating when the injury or illness exposure occurred. Be specific (for example, decorator's scaffolding, electric sander, paintbrush and paint). Enter "NA" if not applicable. NOTE: The items listed do not have to be directly involved in the worker's injury or illness.

SPECIFIC ACTIVITY: Describe the specific activity the worker was engaged in when the accident or illness exposure occurred (for example, sanding ceiling woodwork in preparation for painting).

WORK PROCESS: Describe the work process the worker was engaged in when the accident or exposure occurred, such as building maintenance. Enter "NA" for not applicable if not engaged in a work process (for example, if the worker was walking along a hallway).

HOW INJURY OR ILLNESS OCCURRED: Describe how the injury or illness/abnormal health condition occurred. Be very specific. Include the sequence of events and name any objects or substances that directly injured the worker or made the worker ill. (For example: worker stepped back to inspect work and slipped on some scrap metal. As worker fell, worker brushed against the hot metal.)

WORKER'S/EMPLOYER'S RIGHTS AND RESPONSIBILITIES

If you, the worker, believe that benefits are due you under the Workers' Compensation Act, and your employer or the employer's insurance carrier has failed or refused to make those benefits available to you, you have a right to file a complaint with the New Mexico Workers' Compensation Administration. Workers and employers with questions about rights or responsibilities under the Act may contact an ombudsman at any Workers' Compensation Administration regional office for information and assistance. To do so, call any of the above-listed telephone numbers (8 a.m. to 5 p.m. M-F).