General Services Department
Risk Management Division

Workers' Compensation Bureau

Workers' compensation insurance for all state agencies, the larger Universities and some local public bodies.

NEW MEXICO
GENERAL SERVICES DEPARTMENT

1990 Workers' Compensation Statutes -"New Law"-

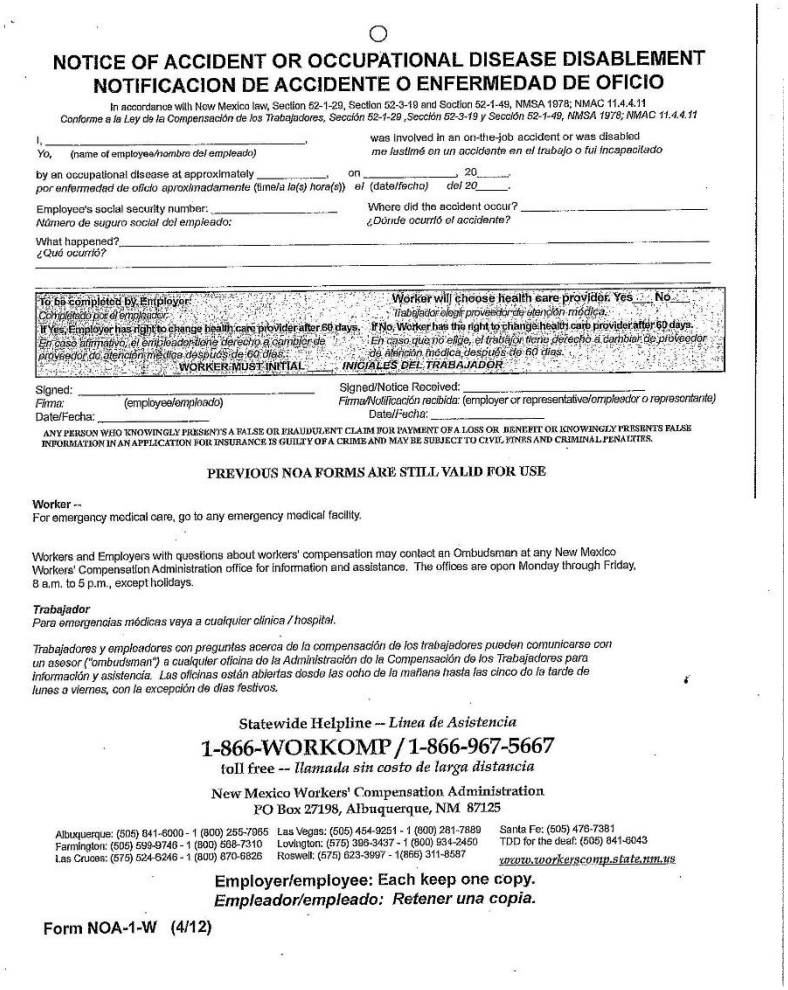
- W.C Information posters must be posted at all work sites.
- Employers should provide training to all employees.
- First choice of medical provider – first [60] days.
- Future *reasonable and necessary* medical treatment for that injury remains open.
- Medical impairments to the injured body part(s) are set by statute.

NEW MEXICO
GENERAL SERVICES DEPARTMENT

Filing a comp claim…

NEW MEXICO
GENERAL SERVICES DEPARTMENT

The employee completes the N.O.A



NOTICE OF ACCIDENT OR OCCUPATIONAL DISEASE DISABLEMENT
NOTIFICACION 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 suguro social del empleado: ¿Dónde ocurrió el accidente?

What happened? _____
¿Qué ocurrió?

_____

_____

To be completed by Employer:
Completado por el empleador:
If Yes, Employer has right to change health care provider after 60 days.
En caso afirmativo, el empleador tiene derecho a cambiar de proveedor de atención médica después de 60 días.
WORKER MUST INITIAL

Worker will choose health care provider. Yes ___ No ___
Trabajador elegir proveedor de atención médica.
If No, Worker has the right to change health care provider after 60 days.
En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 días.
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 clínica / 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 días festivos.

Statewide Helpline -- *Línea 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

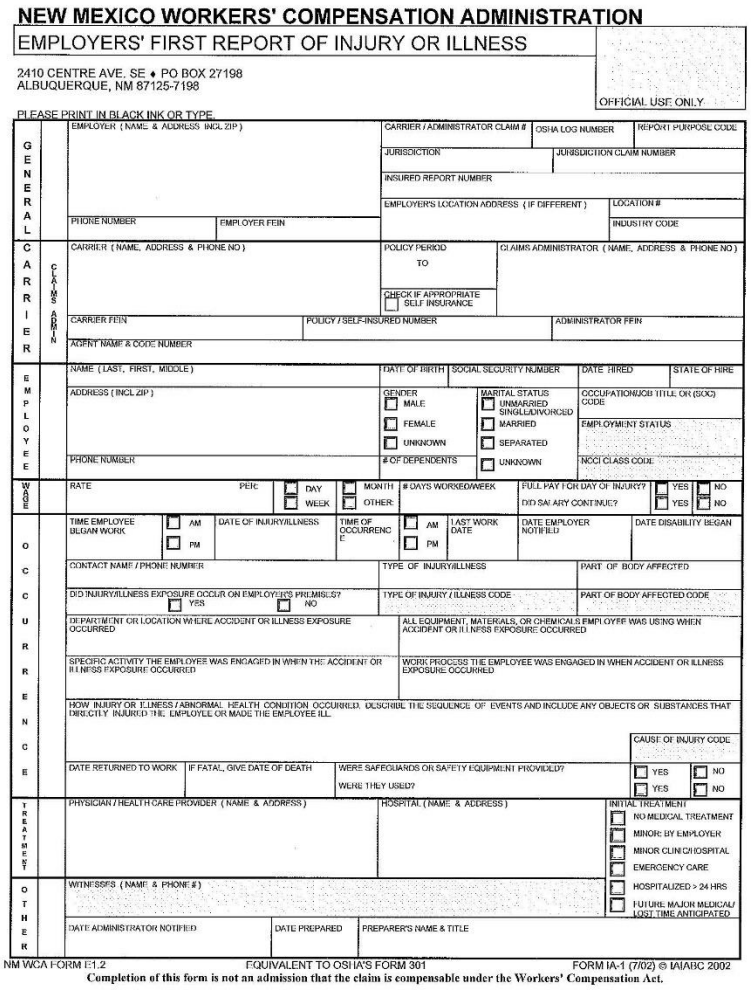
Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 668-7310
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Lovington: (575) 396-3437 - 1 (800) 934-2450
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381
TDD for the deaf: (505) 841-6043
www.workerscomp.state.nm.us

Employer/employee: Each keep one copy.
Empleador/empleado: Retener una copia.

Form NOA-1-W (4/12)

NEW MEXICO
GENERAL SERVICES DEPARTMENT

H/R or Supervisor complete the "E-1"



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) | CARRIER / ADMINISTRATOR CLAIM # | OSHA LOG NUMBER | REPORT PURPOSE CODE
JURISDICTION | JURISDICTION CLAIM NUMBER
INSURED REPORT NUMBER
PHONE NUMBER | EMPLOYER FEIN | EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION # | INDUSTRY CODE

CARRIER
CARRIER (NAME, ADDRESS & PHONE NO) | POLICY PERIOD TO | CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
CHECK IF APPROPRIATE ☐ SELF INSURANCE
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 ? ON 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.

RMD-WCB

NEW MEXICO
GENERAL SERVICES DEPARTMENT

Employee reads and signs HIPAA release

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 NMSA 1978, § 52-10-1, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any work place 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.

RELEASE OF HEALTH CARE RECORDS

I, (Print 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:		

I authorize the following records released (check box, as appropriate): ☐ **ALL RECORDS** / ☐ **SPECIFIC DATES** (provide a date range for records authorized to be released (_____)

Leave Blank

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (initial 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 ☐ Picked Up ☐ Mailed ☐ Emailed ☐ Faxed ☐ Other (specify) _____

Authorized Recipient/s:		
Address:		
Fax/Email:		

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 INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFIYING 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

NEW MEXICO
GENERAL SERVICES DEPARTMENT

Employee reads, initials & signs WC Benefits Explanation Form

WORKERS' COMPENSATION
BENEFITS EXPLANATION FORM

I, _____, acknowledge that the following items have been explained to me and that I do understand each item.

1. §10-7-13 NMSA prohibits public employees from receiving monthly salary for leave time in combination with workers' compensation benefits that exceeds 100% of the employee's monthly base salary. _____ (initials)

2. The workers' compensation benefit is computed at 66 2/3% of the employee's gross weekly base salary UP TO A SPECIFIED CAP For most individuals, this figure is equal to the pay received in 5.3 hours of the normal 8 hour work day and is recorded as Workers' Compensation Leave Without Pay (LWOP). The remaining 2.7 hours are charged to sick and/or annual leave or authorized LWOP. _____ (initials)

3. Unusual deductions such as private medical, dental, and legal insurance can continue as long as the remaining 2.7 hours (or more) per day are taken as sick and/or annual leave. If an employee runs out of sick and/or annual leave, the employee must bear the burden of paying his/her and the state's share of such deductions, unless the employee applies, and is approved for, leave under the Family and Medical Leave Act (FMLA). _____ (initials)

4. The first 5 work days (40 hours, 7 calendar days) that an employee loses time is **NOT** compensated until the employee has been off work for more than 28 calendar days. The first week is initially charged to sick and/or annual leave or authorized LWOP. _____ (initials)

5. After 28 calendar days off work, the first week's benefit check is paid. At this time, unless the employee was on LWOP, or in other words, did not have or use any sick or annual leave for that first 40 hours, the first week's benefit check will constitute an overpayment and violates §10-7-13 NMSA. Therefore, the employee must reimburse the agency for the amount of overpayment received. In return, the agency must reinstate the applicable amount of sick and/or annual leave used during the first week.

_____ (initials)

6. The amount of overpayment will be computed by the agency upon receipt of the first week's check. Should the check be delivered **DIRECTLY** to the employee, it is the employee's responsibility to ensure proper procedures are followed. _____ (initials)

Benefits Explanation Form
Page 2

7. The responsibility for properly coding time sheets rests with the immediate supervisor. The injured employee must also ensure that time sheets are properly and accurately prepared. _____ (initials)

8. Any LWOP time in excess of 30 days, **INCLUDING THAT USED FOR WORKERS' COMPENSATION PURPOSES**, does not allow an individual to accrue service time towards retirement, unless the employee applies, and is approved for FMLA. All other LWOP time must be made up by actual service (productive) time. _____ (initials)

_____
Print name of injured employee

_____
Signature of injured employee

_____
Date

WITNESS:

Name_____

Date_____

NEW MEXICO
GENERAL SERVICES DEPARTMENT

Employee reads & signs WC Claims Explanation form

WORKERS' COMPENSATION
CLAIM EXPLANATION

In reporting this alleged on-the-job injury/occupational illness, which occurred on _____.
I, the undersigned, acknowledge the following items have been explained to me and that I understand each item.

1. By reporting this injury/illness to my supervisor or other designated person I am only complying with requirements of my agency's internal loss prevention procedures and the New Mexico Workers' Compensation Act. _____ (Initials)
2. Reporting the injury/illness does not automatically qualify me for Workers Compensation benefits. _____ (Initials)
3. My employer has the right to either direct me to a health care provider of their choice upon the report of this accident or permit me to select my own health care provider for treatment of my alleged job-incurred injury/illness. I am fully aware that unauthorized treatment may not be a covered Workers' Compensation benefit.

   Choose one and sign.

   A. My employer chooses to select the health care provider for the first 60 days.

   _____ (Name of Physician) _____ (Employee Signature)

   B. My employer will permit me to select the health care provider for the first 60 days.

   _____ (Name of Physician) _____ (Employee Signature)

4. This injury will be investigated by my agency and Risk Management Division, who will determine if the injury/illness qualifies under the guidelines of the Workers' Compensation Act. _____ (Initials)
5. I will be advised by proper authority if particular investigative circumstances or facts **AT THE AGENCY LEVEL** cause the investigating person(s) to believe that the injury/illness is **NOT** within the purview of the Workers Compensation Act. If I am not satisfied with the determination at the agency level, I am aware that I may request reconsideration of my claim by the assigned Workers Compensation Claims Administrator at Risk Management Division at (505) 827-0232. _____ (Initials)
6. My supervisor or a designated agency representative (_____) will be promptly informed of all doctors' appointments, diagnosis/prognosis, billings and/or changes in treatment. _____ (Initials)

All information stated by me regarding this incident, to any person investigating said incident or representing my employer, is true and factual. Any willful untruths or misrepresentations regarding an alleged on-the-the job injury/illness will be regarded as falsification of official documents.

_____ Print name of Employee

_____ Print name of witness

_____ Signature of Employee

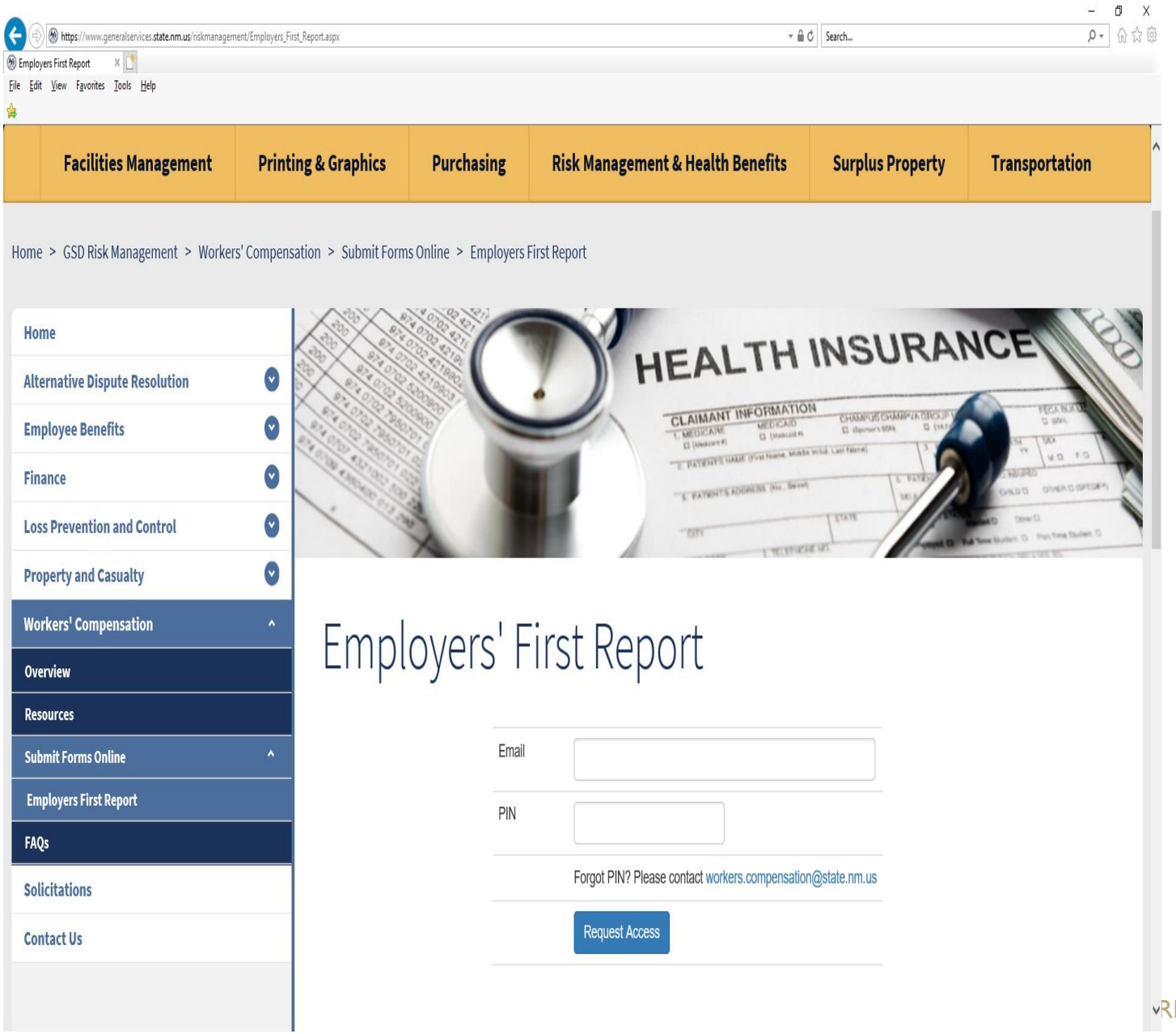
_____ Signature of witness

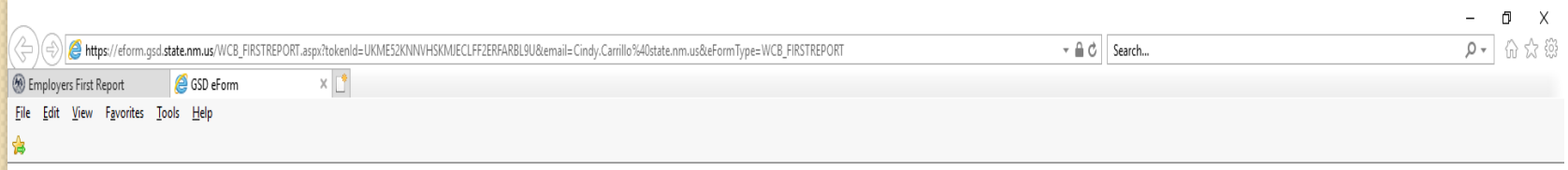
_____ Date

_____ Date

NEW MEXICO
GENERAL SERVICES DEPARTMENT

https://www.generalservices.state.nm.us/riskmanagement/Employers_First_Report.aspx





WORKERS COMPENSATION INJURY REPORTING

Employer: This form must be electronically filed with the GSD/Risk Management Division, Workers' Compensation Bureau within 72 hours of knowledge of any and all alleged work-related injury or illness even if the employer disputes the workers' claim of work –related injury or illness

Instructions for completion:

Please fill in all mandatory fields. Some of the fields have been pre-populated. Incomplete "First report of Injury form" will not be submitted or received.

All other four (4) associated documents are also required to be uploaded to complete the report of injury, Notice of Accident, Medical Release of Information, Witness Statements, Claim Explanation Form, Benefits Explanation Form. You will have to scan them separate in your documents so that you can upload them one at a time.

Risk Management Division/Workers Compensation Bureau
P.O. Box 6850 Santa Fe, New Mexico 87502
Phone: 505 827-0232
Fax: 505 827-0685

* required

Supporting documents

Please upload required supporting documents

Notice of accident * Download Template	Choose file	Upload
Authorization for use and disclosure of Health Records * Download Template	Choose file	Upload
Benefit Explanation Download Template	Choose file	Upload
Claim Explanation * Download Template	Choose file	Upload
Other Employee Records	Choose file	Upload
Medical Records Add		

Employeer Details

Name * *Agency and department.*	
Address * *Street address.*	
City *	
State *	New Mexico
ZIP Code * *Enter either XXXXX or XXXXX-XXXX.*	
Phone * *Person to be contacted about this injury/illness.*	(xxx)-xxx-xxxx
FEIN	Default (85-6000565)
Carrier/Administrator Claim #	85-6000565

Employer's Location (If Different)

Satellite office where employee works.

Name	
Address	
City	
State	New Mexico

Employee Details

First Name *	
Middle Name	
Last Name *	
Address * *Please enter home address.*	
City *	
County *	
State *	New Mexico
ZIP * *Enter either XXXXX or XXXXX-XXXX.*	
Phone Number *	
Date of Birth *	
Social Security Number *	
Date Hired *	
State of Hire *	New Mexico
Gender *	
Marital Status *	

Address Line 1	
City	
State	New Mexico
ZIP	
Initial Treatment *	<- Please select: ->

Other

Witnesses (Name & Phone #) *Please give name and phone number of anyone that witnessed the accident or illness.*	250 characters remaining (250 maximum)
Date Administrator Notified * *Date the administrator/employer was notified.*	7/23/2019
Date Prepared *	
Preparer's Name * *This form should be filled out by employer, not injured worker.*	
Preparer's Title * *This form should be filled out by employer, not injured worker.*	

Submit

Now What?

NEW MEXICO
GENERAL SERVICES DEPARTMENT

Claim Investigation

◊ Assigned Adjuster will determine if claim is compensable based upon *all information* provided *and discovered, medical evidence, statutes and case law.*

◊ *If Adjuster denies the claim, the injured worker has the right to file a complaint with the WCA*.*

◊ *Complaints initially go to mediation, if no agreement is reached it can proceed to trial.*

**WCA: Workers' Compensation Administration*

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GENERAL SERVICES DEPARTMENT

If the claim is accepted

◊ Reasonable and necessary medical is paid until injury is resolved.

◊ This includes reasonable and necessary medical visits, physical therapy, occupational therapy, MRIs, X-Rays', second opinions, independent medical evaluations, etc.

◊ If out of work on Doctors orders', temporary total disability (TTD) is calculated *after* the (7) day waiting period and paid as a workers' compensation benefit.

◊ Temporary partial disability (TPD).

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GENERAL SERVICES DEPARTMENT

Medical Care

◊ In an **EMERGENCY**, the injured worker should be directed to the nearest hospital Emergency Room.

◊ If **NOT** an emergency, the Employer may direct the worker to a medical provider ***or*** allow the worker select their choice of provider for the first [60] days.

◊ Emergency care in the emergency room is *not* considered anyone's selection of healthcare provider.

◊ We **do not** have any contracted providers anywhere in the state.

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Medical care continued…

◊ If the Doctor the injured worker selects does not accept workers' comp insurance let them know they can find another Doctor who will accept WC insurance. Direct them to the WCA for information regarding what Doctors will accept workers' compensation insurance:

WCA: 505-841-6000

LOCATIONS: Santa Fe, Albuquerque, Las Vegas, Farmington, Roswell, Lovington, and Las Cruces.

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GENERAL SERVICES DEPARTMENT

Doctor Query/Modified Duty Form

- This form should be sent with injured worker to Doctor for every medical appointment.
- Can they work ?
- Can they work with restrictions or part-time?
- Is the employer able to accommodate restrictions?
- Is the employer able to provide temporary modified duty, if needed?
- If yes, create modified duty terms on back of Dr. Q form.

NEW MEXICO
GENERAL SERVICES DEPARTMENT

RISK MANAGEMENT DIVISION
DOCTOR VISIT/MODIFIED WORK ASSIGNMENT

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO HIS/HER EMPLOYER AT THE CONCLUSION OF EACH AND EVERY DOCTOR VISIT

DATE _____ EMPLOYER _____

DOCTOR _____ SOCIAL SECURITY # _____

_____

_____ is a State of New Mexico, _____ Department employee. An alleged on the job injury was reported by this employee on _____ which may require treatment, as you determine. Please complete the data below so that a claim may be processed by the Risk Management Division.

Thank you for your cooperation in this matter.

Supervisor	Agency/Division	Phone

1. Diagnosis

2. Was employee released today? Yes ◯ No ◯

3. X-ray(s)? Today: Yes ◯ No ◯

4. Medication prescribed? Yes ◯ No ◯ Continued ◯

5. Can employee return to normal duty at this time? Yes ◯ No ◯

6. If Yes, has the employee reached MMI? Yes ◯ No ◯

7. If "No", can employee return to work on a limited/restricted basis? Yes ◯ No ◯

8. If "Yes" to #6, what restrictions?

☐ NO REACHING ABOVE SHOULDER.
☐ NO CLIMBING OF STAIRS OR LADDERS.
☐ NO LIFTING OVER _____ LBS.
☐ NO KNEELING/SQUATING.
☐ NO PUSHING OR PULLING
☐ NO OPERATION OF MACHINERY
☐ NO REPETITIVE WAIST BENDING.
☐ LIMITED/NO USE OF _____

OTHER _____

How long will restrictions last? Until next visit ☐ Other date _____

9. When is next visit scheduled? _____

10. Other Comments

ATTENDING DOCTOR _____

RMDWC1.RFM(10/93)

MODIFIED WORK ASSIGNMENT

I, _____ have read the restrictions detailed below and have discussed said restrictions with my supervisor/employer,

_____

I understand the nature of the restrictions and further understand that any violations of said restrictions may cause aggravation or further, injury. I also understand and will comply with the rules or orders noted below as a condition of employment on a modified work assignment.

_____

_____

_____

_____

_____

_____ _____
Employees Signature Date

_____ _____
Immediate Supervisor Date

RMDWC2:FRM(10/93)

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GENERAL SERVICES DEPARTMENT

Indemnity benefit payment

◊ If the Doctor orders no work, comp will start benefits on the 8th day of lost time.

◊ Temporary total disability (TTD) is paid at 66 2/3% of the injured workers Average Weekly Wage: This is calculated by the ***gross*** income for the 26 weeks prior to the date of injury. There is a ***maximum*** compensation rate which changes every January.

◊ For 2019 the Maximum rate is: **$814.64**
Minimum rate is $ 36.00

NEW MEXICO
GENERAL SERVICES DEPARTMENT

RISK MANAGEMENT DIVISION
WORKERS' COMPENSATION BUREAU
WORKSHEET FOR COMPUTING AVERAGE WEEKLY WAGE

EMPLOYEE:_____ AGENCY:_____

DATE OF INJURY:_____ DATE OF HIRE:_____

SSN: _____

WAS EMPLOYEE WORKING MORE THAN ONE JOB AT THE TIME OF THE INJURY? ❑Y ❑N

PLEASE PROVIDE 26 WEEKS OF GROSS EARNINGS (13 PAY PERIODS) PRIOR TO DATE OF INJURY. (PLEASE ATTACH PAYROLL RECORDS FOR DOCUMENTATION.)

PAY PERIOD ENDING DATE*	TOTAL GROSS EARNINGS ON PAYCHECK**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

TOTAL FOR 26 WEEKS PRIOR TO DATE OF INJURY: $_____

TOTAL DIVIDED BY 26 = $ _____ (AVERAGE WEEKLY WAGE)

*START WITH PAY PERIOD ENDING MOST RECENTLY PRIOR TO DATE OF INJURY.

** TOTAL GROSS EARNINGS INCLUDES SALARY, OVERTIME, SHIFT DIFFERENTIAL, ETC., BUT NOT MILEAGE, PERDIEM OR FRINGE BENEFITS.
(SECTION 52-1-20, NEW MEXICO WORKERS' COMPENSATION ACT).

G:\WORKCOMP\AWWWORKSHEET.DOC

Average weekly wage form (AWW)

◊ We ask that you complete this form with help from your HR. We need to have an *average weekly wage* according to NM Workers Comp Statues 52-1-20. Attach copies of checks to worksheet.

◊ Includes all **gross** income, overtime, shift differential, as well as any other part time as well.

◊ Impairments are also calculated according to the COMP rate as well. (66 2/3% of AWW, taken from the *average weekly wage form*)

√ EXAMPLE: Average Weekly Wage is (500.00) the Comp rate is $333.33 x 10% = 33.33 per week for the 'whole person'.

◊ <u>Scheduled injury</u>; knee, arm, leg is set number of weeks per the *Workers' Compensation Act*.

NEW MEXICO
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Insurance premiums

NEW MEXICO
GENERAL SERVICES DEPARTMENT

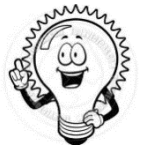
Insurance premiums

◊ Insurance premiums are based on a 5 year history.

◊ Medical, indemnity and additional expenses will make up your loss history.

◊ Early Return to Work and Modified Duty programs save money on premiums.

◊ Premiums are calculated based on your agencies experience and exposure for a trailing 5 year history.



Employers have the greatest impact on premiums by preventing injures, providing early return to work and modified duty programs when injuries do happen.

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Workers' Compensation Bureau Contacts

Bureau Chief

Cindy Carrillo, Bureau Chief	505-476-3871

Adjusters

Andrea Armenta	505-476-3762
Charlene Urban	505-827-0338
Margaret Carrillo	505-476-2174
Grace Chavez	505-476-3787
Amie Martinez	505-827-0445
Theresa Griego	505-827-0432
Ray Silva	575-521-5919

Administrative Support

Pamela Gonzales	505-827-0253
Denise Leyba	505-827-0451
Adriana Garcia	505-827-2036
Bernadette Flores	505-827-0270

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To summarize…

◊ EMPLOYER must ensure posters and "Notice of Accident" are posted at all work sites.

◊ EMPLOYER completes the "First Report of Accident".

◊ EMPLOYER submits ***entire*** *claim package to RMD.*

◊ EMPLOYER decides who will pick HCP (first 60 days)

◊ EMPLOYER communicate with RMD/WCB if modified duty is or is not accepted.

◊Call RMD/WCB with questions: **1-800-510-5093**

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No question is a silly question!

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