ON THE JOB INJURY/ILLNESS

Employees injured while on duty are required to notify their supervisor within 24 hours of the injury. In the event of an injury/illness, the supervisor must ensure that all forms are completed correctly and timely.

PLEASE NOTE: The following forms are required and should be completed for every injury incurred whether or not medical attention was received. (These forms must be submitted to HR within 3 days of incident):

- Notice of Accident (Completed by employee, signed by Supervisor).
- Employer's First Report of Injury/Illness (NM WCA Form E1.2) (Completed by Supervisor, fill out Employee, Wage, Occurrence, Treatment and Other sections).
- Authority to Release Medical Reports and information (Fill out Section 1, 2 and 11, employee signature, date and witness signature and date (Required).
- 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 when medical attention is/was received).
- Worker's Compensation Claim Explanation (Fill out entire form, (Section 5- initial one NOT BOTH).
- Worker's Compensation Benefits Explanation Form (Fill out entire form including WITNESS section).
- Fax completed forms to Ashley Archuleta at (505) 476-3399

IMPORTANT NOTICE!!! PLEASE BE ADVISED:

If an injury is very serious and possibly life-threatening, the employee must be transported to the nearest emergency medical facility. In such cases, call 911 or the nearest medical facility to determine whether emergency medical personnel should be dispatched.

For questions regarding Worker's Compensation, please contact Ashley Archuleta, Worker's Comp Administrator at (505) 476-3246.

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

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

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

by an occupational disease at approximately _____, on _____, 20_____.
por enfermedad de oficio aproximadamente (time/*la(s) hora(s)*) *el* (date/*fecha*) *del* 20_____.

Employee's social security number: _____ Where did the accident occur? _____
Número de seguro social del empleado: *¿Dónde ocurrió el accidente?*

What happened?_____
¿Qué ocurrió?

_____

_____

To be completed by Employer:
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 will choose health care provider. Yes___ No___
Trabajador elegirá 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.

WORKER MUST INITIAL ____ ***INICIALES DEL TRABAJADOR***

Signed: _____ Signed/Notice Received: _____
Firma: (employee/*empleado*) *Firma/Notificación recibida:* (employer or representative/*empleador o representante*)
Date/Fecha: _____ Date/*Fecha*: _____

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

PREVIOUS NOA FORMS ARE STILL VALID FOR USE

Worker --
For emergency medical care, go to any emergency medical facility.

Workers and Employers with questions about workers' compensation may contact an Ombudsman at any New Mexico Workers' Compensation Administration office for information and assistance. The offices are open Monday through Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador
Para emergencias médicas vaya a cualquier clinica / hospital.

Trabajadores y empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualquier oficina de la Administración de la Compensación de los Trabajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hasta las cinco de la tarde de lunes a viernes, con la excepción de días festivos.

Statewide Helpline -- *Linea de Asistencia*

1-866-WORKOMP / 1-866-967-5667

toll free -- *llamada sin costo de larga distancia*

New Mexico Workers' Compensation Administration
PO Box 27198, Albuquerque, NM 87125

Albuquerque: (505) 841-6000 - 1 (800) 255-7965
Farmington: (505) 599-9746 - 1 (800) 568-7310
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Lovington: (575) 396-3437 - 1 (800) 934-2450
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381
TDD for the deaf: (505) 841-6043
www.workerscomp.state.nm.us

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

Form NOA-1-W (4/12)

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)
Energy, Minerals & Natural Resources Department
1220 South St. Francis Drive
Santa Fe NM 87505

PHONE NUMBER: (505) 476-3246
EMPLOYER FEIN: 85-60000565

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)
Risk Management Division
Worker's Comp Bureau
PO Drawer 26110
Santa Fe, NM 87502

CARRIER FEIN: 85-60000565

POLICY PERIOD
TO
CHECK IF APPROPRIATE
☒ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
Risk Management Division
1100 St. Francis Drive
Santa Fe NM 87502
(505) 827-0232

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)
PHONE NUMBER
GENDER: ☐ MALE ☐ FEMALE ☐ UNKNOWN
OF DEPENDENTS
MARITAL STATUS: ☐ UNMARRIED SINGLE/DIVORCED ☐ MARRIED ☐ SEPARATED ☐ UNKNOWN
OCCUPATION/JOB TITLE OR (SOC) CODE
EMPLOYMENT STATUS
NCCI CLASS CODE

WAGE

RATE | PER: ☐ DAY ☐ WEEK ☐ MONTH ☐ OTHER: | # DAYS WORKED/WEEK | FULL PAY FOR DAY OF INJURY? ☐ YES ☐ NO | DID SALARY CONTINUE? ☐ YES ☐ NO

OCCURRENCE

TIME EMPLOYEE BEGAN WORK | ☐ AM ☐ PM | DATE OF INJURY/ILLNESS | TIME OF OCCURRENCE | ☐ AM ☐ PM | LAST WORK DATE | DATE EMPLOYER NOTIFIED | DATE DISABILITY BEGAN

CONTACT NAME / PHONE NUMBER
Ashley Archuleta 476-3246

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.

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
Phone: (505) 841-6000 **In-State Toll Free: 1-800-255-7965**
FARMINGTON: 599-9746/1-800-568-7310 **LAS CRUCES:** 524-6246/1-800-870-6826
LAS VEGAS: 454-9251/1-800-281-7889 **LOVINGTON:** 396-3437/1-800-934-2450

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).

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 (_____)

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

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 _____

RMDWCI 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

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

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)

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_____