SANDOVAL COUNTY

SUMMER YOUTH EMPLOYMENT

PROGRAM

SUPERVISOR HANDBOOK

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WELCOME TO THE 2017 SANDOVAL COUNTY SUMMER YOUTH EMPLOYMENT PROGRAM (SYEP)!

Thank you for your participation in the 2017 SYEP. The 2017 SYEP will begin on June 5, 2017 and end on July 28, 2017. As a Worksite Supervisor you are in the unique position of providing supervision and training to youth in our community. Your participation will help young people ages 15 to 17 develop positive work habits, attitudes and job skills. You can make a difference in preparing the youth you supervise for future employment. Your participation is essential to the success of the SYEP.

This year's program is facilitated by **Sandoval County Human Resources Office.** We can be reached at:

Sandoval County Administration (1st Floor)
1500 Idalia Road, Building D
Bernalillo, NM 87004
MAIN: (505) 867-7505
FAX: (505) 867-9365

Should you have **any** questions or concerns please contact your **2017 SYEP Program Coordinator:**

Michelle Jones (505) 867-7505 mjones@sandovalcountynm.gov

Thank you for your support and we look forward to working with you!

I. STANDARDS AND GUIDELINES

The following standards and guidelines will be explained to all SYEP participants prior to the start of their work experience. You may have additional guidelines; if so, please make your youth employees aware of them on their first day of work.

1. **ATTITUDE / WORK PLACE DEMEANOR** – Participants are expected to have a positive attitude and to conduct themselves appropriately. If a participant has a negative attitude, or exhibits a demeanor or behavior not suited to the workplace, call the Program Coordinator to discuss the situation.
2. **PUNCTUALITY** – Participants are expected to arrive at their worksite on time. Continual tardiness or unexcused time off may result in termination from the SYEP program.
3. **ABSENCE** – Participants will be given information prior to their first day in the program advising them on how to report an absence. Worksite supervisors should remind youth employees of reporting procedures on their first day at the worksite.
4. **VISITORS** – Participants may not bring or accept visitors at their worksite, including children.
5. **PERSONAL BELONGINGS –** Participants are informed that personal belongings, such as cell phones, electronic devices, etc., are not to be used while at the worksite. All valuable belongings should be left at home. Neither the SYEP employer nor Sandoval County is responsible for lost or stolen items.

If you have a problem getting a youth worker to follow these guidelines, talk to them about the problem and describe your expectations. If the problem continues, call the SYEP Program Coordinator to discuss the next steps.

II. PROGRAM SUSPENSION AND/OR TERMINATION

The categories below constitute potential grounds for suspension and/or termination from the SYEP. As a Worksite Supervisor, you are not expected to keep youth at your worksite if they display inappropriate workplace behavior. If you, or anyone else at the worksite, are a witness to this type of behavior, send the participant(s) home for the day and immediately contact the Sandoval County Human Resources Office to determine if the youth should be terminated from the program.

- Fraud or dishonesty
- Under the influence of alcohol /drugs or possession of alcohol /drugs or drug paraphernalia
- Misuse or abuse of property
- Inappropriate access to internet/sites
- Fighting or use of abusive language
- Inappropriate attire – repeated violation of dress code
- Continuous absenteeism or tardiness
- Refusal to participate
- Disruptive behavior or attitude
- Theft

III. DRESS CODE

Below is a description of the SYEP dress code. This information has been provided to your youth participants and should be enforced.

1. No oversized T-shirts, shirts with inappropriate words or slogans, halters or tank tops.
2. No head rags, wave caps, bandanas, or hats (unless approved by your Worksite Supervisor).
3. No over-sized pants that may sag or any gang-related attire.
4. No shorts (unless approved by the Worksite Supervisor).
5. No revealing or see-through clothing.
6. Appropriate footwear that follows worksite safety guidelines.

IV. INTERNET ACCESS

Use of the internet should be carefully controlled. The internet should be used only to complete work assignments.

V. THINGS TO REMEMBER WHEN WORKING WITH YOUTH

As a Worksite Supervisor you are expected to provide supervision to the participants assigned to your worksite. When giving work assignments, keep the following in mind:

- If you have more than one participant assigned to your worksite, remember that the age range for the program is 15-17. The younger participants may need more instruction.
- Provide clear instructions and deadlines.
- Make sure that the participant has the skills, training and tools/resources necessary to successfully complete their assignments.
- Make participants accountable for their time and for their assignments. The purpose of the SYEP is to teach the participants skills that will help them in the future.
- Address problems as they arise – sometimes discussing problems(s) is a great teaching opportunity.
- Ensure that the worksite and the work assignments are structured in a way to insure safety. No one wants injuries.

VI. CHILD LABOR LAWS

Child Labor Laws must be followed when working with youth under the age of eighteen (18):

MINIMUM AGE

The minimum age for employment is fourteen (14) in specified occupations outside school hours for limited periods of time.

CERTIFICATES

A work permit certificate is required by state law, for the employment of children less than sixteen (16) years of age AT ALL TIMES.

There is no provision in the law for age certificates for children sixteen (16) and older. An age certificate can be issued upon request to verify the child's age.

Work permits and age certificates are proof of age only and do not authorize prohibited employment.

HOUR LIMITATIONS

Minor 14 and 15 years of age may NOT be employed:

- during school hours
- before 7 a.m. or after 7 p.m., except from June 1 through Labor Day when evening hours are extended to 9 p.m.
- more than 3 hours a day - on a school day
- more than 18 hours a week - in a school week
- more than 8 hours a day - on a non-school week
- more than 40 hours a week in a non-school week

There are no hour or time restrictions for minors age 16 and older.

These time restrictions are consistent with the Fair Labor Standards Act (FLSA).

PROHIBITED OCCUPATIONS FOR MINORS AGES 14 and 15

Established by the Fair Labor Standards Act (FLSA)

Occupations involving:

- mining
- manufacturing
- processing including laundry and dry cleaning
- duties in workrooms
- public messenger service
- hoisting apparatus' or any power driven machinery
- power driven mowers / cutters
- the use of auto pits, racks lifting apparatus'.

Occupations in connection with:

- transportation of persons or property
- warehousing and storage
- communications
- public utilities
- construction

Occupations in retail food / gas service establishment:

- work in boiler / engine rooms
- maintenance / repair of machines and equipment
- outside window washing
- cooking and baking
- operating, setting up, adjusting, cleaning, oiling or repairing power-driven food slicers, grinders, choppers and mixers
- work in freezers / coolers
- loading and unloading goods

And, any occupations found and declared hazardous by FLSA

HAZARDOUS OCCUPATIONS FOR MINORS AGE 16 and 17

Established by the Fair Labor Standards Act (FLSA)

Occupations involving or in connection with:

- explosives
- motor-vehicle drivers
- mining, including coal mining
- logging including sawmill
- power-driven wood working machinery
- radioactive substances
- hoisting apparatus:
  elevators, cranes, derricks, hoists, and high-lift trucks
- metal forming, punching, shearing machines
- slaughtering / meat packing
- power-driven bakery machines
- paper product machines
- manufacture of brick, tile and kindred products
- circular saws, band saws, and guillotine shears
- wrecking, demolition, and ship breaking
- roofing occupations and
- excavation operations

The above-mentioned occupations are prohibited for anyone under the age of eighteen (18). This minimum age applies even when the minor is employed by a parent / guardian.

VII. ACCIDENTS AND INJURIES

Worksite Safety:

In addition to following Child Labor Laws, the following activities are not approved for any of the SYEP participants regardless of their age:

- No SYEP participants are authorized to drive a vehicle as part of their assignment.
- Participants should not be asked to lift heavy objects without help from others.
- Participants should be required to wear any safety gear that will reduce potential injuries.
- Let participants know emergency procedures such as exits and escape plans in case of an emergency.

Below are some helpful websites if you want more safety information:

http://www.osha.gov/SLTC/teenworkers/index.html

http://www.youthrules.dol.gov/

Everyone knows that **safety is a priority** – don't let the SYEP participants assigned to your worksite take any unnecessary chances.

All SYEP participants are covered by Worker's Compensation Insurance by Sandoval County. If an SYEP participant is injured while working, the injury must be reported immediately to the Sandoval County Risk Management Office.

If there is an extreme emergency, immediately call 911. Once the youth employee is under the care of emergency personnel, immediately call the **Risk Management Hotline** at (505) 239-1610 to report the incident.

What to do if there is an injury?

If there is an injury at the worksite that requires a doctor's visit (even if it is a first aid injury) a **Notice of Accident** form and the **HIPPA Medical Release Authorization** form (see attached samples on pages 14, 15 and 16) must be filled out by the participant and the Worksite Supervisor and returned immediately to the Risk Management Supervisor in the Human Resources & Risk Management Office.

If there is any kind of injury at the worksite, please also complete the **Supervisor's Report of Accident** form found on page 17 and return it to the Risk Management Coordinator in the Risk Management Office. Sometimes a minor injury such as a cut can become infected or a bruise can become a sprain, so documenting the facts that caused the injury immediately will be helpful in filling out other required Sandoval County forms later.

VII. HARASSMENT AND DISCRIMINATION POLICY

Pursuant to Sandoval County's Personnel Rules and Regulations and Sexual Harassment Policy, it is the policy of Sandoval County that all County employees (which includes SYEP participants) have a right to work in an environment free of discrimination and unlawful harassment. Sandoval County's SYEP maintains a strict policy of prohibiting discrimination, sexual harassment and harassment because of race, national origin, sexual orientation, physical or mental disability, age, gender, marital status, military status, religion, political affiliation or any other basis protected by federal, state or local law or regulation. Any and all such harassment or discrimination is unlawful. Unlawful harassment in any form; including verbal, physical and visual conduct, threats, demands or retaliation is unacceptable and will not be tolerated.

"Harassment" includes but is not limited to:

- Verbal conduct such as insults, slurs, derogatory or obscene comments and/or jokes regarding a person's age, gender, race, disability, religion, or on any other basis protected by law; unwanted sexual or romantic advances, invitations, or comments;
- Visual conduct such as display of derogatory posters, photographs, cartoons, drawings, text messages, or gestures;
- Physical conduct such as assault, indecent exposure; unwanted touching, non-verbal gestures, leering, whistling, blocking normal movement, or interfering with work directed at an employee because of the employee's sex, age, race or any other basis protected by law;
- Threats or demands to submit to sexual requests in order to keep a job or avoid some other loss, and offers of job benefits in return for sexual favors; and
- Retaliation for having reported or threatened to report discrimination or harassment.

Participating SYEP employers are responsible for ensuring their company employees, customers, suppliers or other non-employees who conduct business with the employer do not discriminate against, harass or sexually harass SYEP participants; for providing mechanisms for SYEP participants to report discrimination or harassment as required by law; and for immediately notifying the Sandoval County Human Resources Office of any alleged instances of discrimination or harassment of SYEP employees in their workplace, regardless of whom is the alleged harasser.

IX. PAYROLL PROCESS

SYEP participants must document actual hours worked by completing and signing their bi-weekly timesheets (sample timesheet on page 13). The SYEP Program Coordinators will provide you with this form.

Things to Remember:

- SYEP participants are authorized to work up to 20 hours per work.
- SYEP participants will be paid $7.50 per hour.
- Timesheets must be signed by the SYEP participant and the Worksite Supervisor prior to submittal to the Sandoval County Human Resources Office.
- By signing the timesheet the Worksite Supervisor and the SYEP participant are certifying that the time submitted is a true and accurate record for any worked time for the given time period. **Time cards should not be filled out or signed prior to work hours being completed.**
- If a participant's check is lost or incorrect - the SYEP Program Coordinators should be contacted immediately.
- Holidays may fall within the work program. Please note that SYEP participants **will not be paid for non-worked holidays and they will not be eligible for overtime/holiday pay.** If a holiday impacts a work schedule, the youth may work additional hours during the remainder of the week to make their full weekly hour commitment.
- Youth employees may have questions about their checks – to help you answer them keep in mind:

    - Their first check will be issued on **June 24** – two weeks after they begin their work assignments. They may be confused about why they have to wait two weeks to get their checks. Let them know that this is because the Sandoval County pay cycle is bi-weekly (every other week), so they will always receive their check the week after they submit their signed timesheet.
    - Youth may not understand the difference between "gross" (the amount before taxes) and "net" (the amount after taxes) – you may need to explain this to them.
    - If the youth employees have questions about the taxes taken out of their checks, please feel free to have them call the Sandoval County Finance Department at 867-7534.
    - Remember that the youth employees do not qualify for medical or other County benefits.

Timesheet Turn-In/Check Delivery

Signed timesheets (sample timesheet on page 13) are due to the Sandoval County Human Resources Office **no later than 11:00 a.m.** on the Friday due date. Late timesheets may result in the SYEP participant not receiving his/her paycheck on time. Paychecks will be mailed to the youth employee's home address.

Timesheets can be emailed, hand-carried or faxed to:

Michelle Jones
SANDOVAL COUNTY ADMINISTRATION BUILDING (1st Floor)
HUMAN RESOURCES OFFICE
FAX (505) 867-9365
mjones@sandovalcountynm.gov

Timesheet Due Dates/Pay Dates:

2017 TIME SHEET SCHEDULE

FOR PERIOD	DUE DATE Friday by 11:00 a.m. NO EXCEPTIONS	PAY DAY (Friday)
6/05 thru 6/16 – 40 hrs.	6/16	6/23
6/17 thru 6/30– 40 hrs.	6/30	7/07
7/01 thru 7/14 – 40 hrs.	7/14 (7/4 Independence Day Holiday – Unpaid if not worked)	7/21
7/15 thru 7/28 – 40hrs.	7/28	8/04

Sample
SYEP Forms

SANDOVAL COUNTY
SUMMER YOUTH EMPLOYMENT PROGRAM
TIME SHEET

DUE: XXXXX

Email to mjones@sandovalcountynm.gov, Fax to (505) 867-9365 or deliver to 1500 Idalia Rd. Building D, Bernalillo, NM 87004

EMPLOYEE NAME:_____ PHONE:_____

MAILING ADDRESS:_____

_____

WORKSITE/POSITION:_____

DAY	1ST WEEK		DAY	2ND WEEK	
	DATE	# OF HOURS WORKED		DATE	# OF HOURS WORKED
SATURDAY			SATURDAY		
SUNDAY			SUNDAY		
MONDAY			MONDAY		
TUESDAY			TUESDAY		
WEDNESDAY			WEDNESDAY		
THURSDAY			THURSDAY		
FRIDAY			FRIDAY		

Total Week 1_____ Total Week 2 _____

PAY PERIOD TOTAL HOURS:_____

Cannot exceed 40 hours per pay period

Supervisors: Please complete evaluation:

EVALUATION REPORT:	Excellent	Good	Needs Improvement
1. Attendance			
2. Observes Work Rules			
3. Dress and Grooming			
4. Accepts Direction			
5. Accepts Responsibility			
6. Initiative			

I, the undersigned, certify that this is a true and accurate record of my hours worked for the identified pay period.

_____ _____ _____ _____

Participant Signature Date Worksite Supervisor Signature Date

Print Name Print Name

NMCIA
Workers' Compensation Claim Filing Packet

PLEASE COMPLETE THE FOLLOWING FORMS
FOR ANY WORK RELATED INJURY:

1. Notice of Accident (Must be completed & signed by injured worker) – Required

2. Employers' First Report of Injury or Illness (Must be typed & completed by Supervisor, Not the injured worker) – Required

NOTE: Please ensure the EMPLOYEE section includes employee's home address, personal phone number, date of birth, social security number, date of hire, sex, marital status, job titles and hourly wage. This information is essential for the WC adjuster to correspond with the employee and ensure the appropriate benefits are received.

3.Supervisor's Report of Accident (Completed by Supervisor) -- Required
- a.Witness Statement of Accident Form – If applicable
- b.Infectious Disease Exposure Form – If applicable

4.Worker's Authorization for Disclosure of Protected Health Information for Workers' Compensation Purposes (HIPAA COMPLIANT – Completed by injured worker, signed as required) – Required

****** Once the claim packet has been completed, you are to submit it to the Workers' Compensation Claim Contact for your county. ******

CLAIM CONTACT:

Antonio Corrales
Sandoval County Quality Assurance & Risk Manager
O (505) 404-5866 C (505) 697-7158
Email: avcorrales@sandovalcountynm.gov

Michele Rael
Sandoval County Risk & Safety Specialist
O (505) 867-7504 C (505) 239-1610
Email: mrael@sandovalcountynm.gov

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

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

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 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 the 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 elegir proveedor de atención mèdica.
If No, Worker has the right to change health care provider after 60 days.
En caso que no elige, el trabajor tiene derecho a cambiar de proveedor de atención médica despès de 60 días.

WORKER MUST INITIAL ____ INICIALES DEL TRABADOR ____

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.

Worker—
For emergency medical care, go to any emergency medical facility.
For medical care that is not an emergency, get instructions from your supervisor on where to go for medical care.

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 thru Friday, 8 a.m. to 5 p.m., except holidays.

Trabajador
Para emergencies médicas vaya a cualquier clínica / hospital.
Para tratamiento medico que no sea emergencia, obtenga instrucciones de su supervisor para que le indique a donde ir para obtener asistencia médica.

Trabajadores 7 empleadores con preguntas acerca de la compensación de los trabajadores pueden comunicarse con un asesor ("ombudsman") a cualiquier oficina de la Administración de la Compensación de los Trobajadores para información y asistencia. Las oficinas están abiertas desde las ocho de la mañana hast alas 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 Las Vegas: (505) 454-9251 - 1(800) 281-7889 Santa Fe: (505)476-7381
Farmington: (505) 599-9746 - 1(800) 568-7310 Lovington: (575)396-3437 - 1(800) 934-2450 TDD for the deaf: (505)841-6043
Las Cruces: (505)524-6246 - 1(800)870-6826 Roswell: (575)623-3997 – 1(866) 311-8587 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)
Sandoval County
1500 Idaho Road
Bernalillo, NM 87004

CARRIER / ADMINISTRATOR CLAIM # | OSHA LOG NUMBER | REPORT PURPOSE CODE

JURISDICTION | JURISDICTION CLAIM NUMBER

INSURED REPORT NUMBER

EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT) | LOCATION #

PHONE NUMBER 505-867-7500 | EMPLOYER FEIN 85-6000244 | INDUSTRY CODE

CARRIER / CLAIMS ADMIN

CARRIER (NAME, ADDRESS & PHONE NO)
NMAC – NM Association of Counties (NMCIA)
444 Galisteo St.
Santa Fe, NM 87501
505-980-2101

POLICY PERIOD ____ TO ____

CHECK IF APPROPRIATE ☐ SELF INSURANCE

CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)
NM Association of Counties (NMCIA)
444 Galisteo St.
Santa Fe, NM 87501
505-980-2101

CARRIER FEIN 85-0203345 | POLICY / SELF-INSURED NUMBER | ADMINISTRATOR FEIN 85-0203345

AGENT NAME & CODE NUMBER

EMPLOYEE

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

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)
Manzano Medical Group
505 Elm Street NE
Albuquerque, NM 87102

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).

NMCIA
3. SUPERVISOR'S REPORT OF ACCIDENT

County: _____ Department: _____
Employee Name: _____ Date: _____

Form to be completed by injured/affected employees' supervisor.

JOB CLASSIFICATION

- ☐ Administration/Clerical
- ☐ Animal Control
- ☐ Custodian
- ☐ Detention Officer/Supervisor
- ☐ EMT/Paramedic
- ☐ Equipment Operator
- ☐ Field Worker/Crew Member
- ☐ Firefighter (Paid or Volunteer)
- ☐ Law Enforcement Officer/Supervisor
- ☐ Maintenance Worker
- ☐ Mechanic
- ☐ Supervisor
- ☐ Truck Driver
- ☐ Welder
- ☐ Other _____

TYPE OF CONTACT

- ☐ Animal
- ☐ Assault, e.g., offender assaults
- ☐ Caught In, On, Between, or Under
- ☐ Contact With, e.g. bloodborne pathogen, chemical, noise, weather extremes, etc.
- ☐ Fall from Elevation, e.g., different height
- ☐ Fall from same Level
- ☐ Motor Vehicle Accident
- ☐ Overexertion, e.g., strains, ergonomic, etc.
- ☐ Struck By or Against
- ☐ Other _____

CAUSE(S)

Unsafe Act(s)

- ☐ Failure to use PPE
- ☐ Horseplay/misuse
- ☐ Improper lifting/loading
- ☐ Operation without authority/training
- ☐ Working on equipment in operation
- ☐ Other _____

Unsafe Condition(s)

- ☐ Defective tools, equipment, or material
- ☐ Fire & explosion hazard
- ☐ Inadequate engineering controls
- ☐ Inadequate guards or barriers
- ☐ Inadequate illumination
- ☐ Inadequate or improper PPE
- ☐ Inadequate maintenance
- ☐ Inadequate supervision
- ☐ Inadequate warning system
- ☐ Inadequate ventilation
- ☐ Lack of experience (skill)
- ☐ Lack of knowledge (training)
- ☐ Poor housekeeping
- ☐ Other _____

Event Description: _____

_____

_____

_____

_____

_____

_____

_____

Does County/Department have policy or procedure for this activity?	**YES**	**NO**
If so, was the policy or procedure followed?	**YES**	**NO**

PREVENTATIVE MEASURES TAKEN

- ☐ Counsel/sanction employee/supervisor
- ☐ Repair tool, equipment, or material
- ☐ Improve design or layout
- ☐ Improve housekeeping
- ☐ Improve maintenance
- ☐ Provide proper PPE
- ☐ Train employee
- ☐ Train supervisor
- ☐ No Action Practical
- ☐ Other _____

Policy/Procedures

- ☐ Develop new policy/procedure
- ☐ Enforce policy/procedure
- ☐ Revise policy/procedure

What action was taken to prevent similar occurrences? _____

_____

_____

_____

_____

_____

Supervisor Name: _____ Date: _____

Employee Signature: _____ Date: _____

Loss Prevention Coordinator and/or Safety Committee Concurrence: **YES** **NO**

NMCIA
3 a. WITNESS STATEMENT OF ACCIDENT

FORM IS TO BE COMPLETED BY THE INVOLVED WITNESS AND FORWARDED TO RISK MANAGEMENT WITHIN TWO (2) WORKING DAYS OF THE OCCURANCE.

Accident of: _____ Date of Accident: _____
(Name of person who had accident)

Name of Witness: _____ Employer: _____

Date of Statement: _____ Time of Statement: _____

Home Phone #: _____ Work Phone #: _____

Home Address: _____

Location of Accident: _____

_____

Describe the accident or incident in your own words and just as you saw it happen:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Witness's Signature Date Date

NMCIA
3 b. INFECTIOUS DISEASE EXPOSURE

Continuation of Supervisor's Accident Investigation Report for accident on

_____ for _____.
(Date) (Name of Employee [First – Middle – Last])

Potential Exposed Individual:

Name: _____
(First – Middle – Last)

Address: _____
(Home Address) (City) (State) (Zip)

Date of Birth: _____

Type of Exposure:

Airborne _____ Blood _____ Feces _____

Saliva _____ Sputum _____ Tears _____

Urine _____ Vomitus _____

Other / Specify _____

Personal Protective Equipment Used:

Eye Protection _____ Gloves _____

Gown _____ Mask _____

Other / Specify _____

Do you have any open cuts, sores, rashes, or other physical problems that were not covered that were exposed? Be Specific _____

_____

_____ _____ _____
Supervisor's Name (Printed) Supervisor's Signature Date

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.

Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman.

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

Revised 7/26/16