

SANDOVAL COUNTY SUMMER YOUTH EMPLOYMENT PROGRAM



SUPERVISOR HANDBOOK

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WELCOME TO THE 2016 SANDOVAL COUNTY SUMMER YOUTH EMPLOYMENT PROGRAM (SYEP)!

Thank you for your participation in the 2016 SYEP. The 2016 SYEP will begin on June 6, 2016 and end on July 29, 2016. 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 **2016 SYEP Program Coordinator**:

Michelle Jones (505) 867-7505

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 iPods, MP3 players, cell phones, blackberries, 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 12:00 p.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 hand-carried or faxed to:

Michelle Jones
SANDOVAL COUNTY ADMINISTRATION BUILDING (1st Floor)
HUMAN RESOURCES OFFICE
PHONE (505) 867-7505
FAX (505) 867-9365

Timesheet Due Dates/Pay Dates:

2016 TIME SHEET SCHEDULE

FOR PERIOD	DUE DATE (by 12:00 P.M.)	PAY DAY
<u>6/6 thru 6/17</u> – 40 hrs.	6/17	6/24
<u>6/20 thru 7/01</u> – 40 hrs.	7/01	7/08
7/05 thru 7/15 – 40 hrs.	7/15 (7/04 – July 4th Holiday)	7/22
<u>7/18 thru 7/29</u> – 40hrs.	7/29	8/05

Sample SYEP Forms

NMCIA

Workers' Compensation Claim Filing Packet

PLEASE COMPLETE THE FOLLOWING FORMS
IF YOU WERE INJURED ON THE JOB:

1. Notice of Accident (**Must** be completed & signed by **Employee**) – **Required**
2. Employers' First Report of Injury or Illness (**Must** be typed & completed by **Supervisor, NOT THE EMPLOYEE**) – **Required**

NOTE: Supervisor's must 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 Employee, signed as required) – **Required**
5. Claim Explanation Form (Employee read, initial and sign) – **Required**
6. Benefits Explanation Form (Employee read, initial and sign) – **Required**
7. Authorization to Communicate Directly with HCP (Employee read, complete and sign) – **Required**
8. Employee's Disability Statement
9. Modified Work Assignment (Employer completes; employee and supervisor sign) – If applicable
10. Doctor Visit / Modified Work Assignment (Employer may give to employee for use with health care provider) – If applicable

***** 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?

<p>To be completed by Employer: Completado por el empleador: <small>If Yes, Employer has the right to change health care provider after 60 days. In case affirmative, the employer bene derecho a cambiar de proveedor de atención médica después de 60 días</small></p>	<p>Worker will choose health care provider. Yes ___ No ___ Trabajador elegir proveedor de atención médica. <small>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</small></p>
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 emergencias 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 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 hast alas 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) 841-8000 - 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) 311-8567 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.

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP) Sandoval County 1500 Idalia 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			
C A R R I E R	C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO) NMAC – New Mexico Association of Counties (NMCIA) 444 Galisteo Street Santa Fe, NM 87501 505-980-2101		POLICY PERIOD TO		CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO) NM Association of Counties (NMCIA) 444 Galisteo Street Santa Fe, NM 87501 505-980-2101	
		CARRIER FEIN 85-0203345		POLICY / SELF-INSURED NUMBER		ADMINISTRATOR FEIN 85-0203345	
		AGENT NAME & CODE NUMBER					
E M P L O Y E E	NAME (LAST FIRST MIDDLE)		DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE HIRED	STATE OF HIRE NM	
	ADDRESS (INCL ZIP)		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> UNKNOWN	MARITAL STATUS <input type="checkbox"/> UNMARRIED SINGLE/DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> UNKNOWN		OCCUPATION/JOB TITLE OR (SOC) CODE	
	SHOW# NUMBER		# OF DEPENDENTS		EMPLOYMENT STATUS		
					NCCI CLASS CODE		
W A G E	RATE		PER <input type="checkbox"/> DAY <input type="checkbox"/> MONTH <input type="checkbox"/> WEEK <input type="checkbox"/> OTHER	# DAYS WORKED/WEEK	FULL PAY FOR DAY OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
					DID SALARY CONTINUE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK <input type="checkbox"/> AM <input type="checkbox"/> PM		DATE OF INJURY/ILLNESS	TIME OF OCCURRENCE <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST WORK DATE	DATE EMPLOYER NOTIFIED	DATE DISABILITY BEGAN
	CONTACT NAME / PHONE NUMBER Michele Racl – 505-867-7504		TYPE OF INJURY/ILLNESS		PART OF BODY AFFECTED		
	DID INJURY/ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES? <input type="checkbox"/> YES <input type="checkbox"/> 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?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
		WERE THEY USED?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
T R E A T M E N T	PHYSICIAN / HEALTH CARE PROVIDER (NAME & ADDRESS) Manzano Medical 505 Elm Street NE Albuquerque, NM 87102			HOSPITAL (NAME & ADDRESS)		INITIAL TREATMENT <input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSPITAL <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED > 24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL / LOST TIME ANTICIPATED	
	WITNESSES (NAME & PHONE #)						
O T H E R	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) © IA/ABC 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: _____

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 _____

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

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	
<input type="checkbox"/> Counsel/sanction employee/supervisor	Policy/Procedures <input type="checkbox"/> Develop new policy/procedure <input type="checkbox"/> Enforce policy/procedure <input type="checkbox"/> Revise policy/procedure
<input type="checkbox"/> Repair tool, equipment, or material	
<input type="checkbox"/> Improve design or layout	
<input type="checkbox"/> Improve housekeeping	
<input type="checkbox"/> Improve maintenance	
<input type="checkbox"/> Provide proper PPE	
<input type="checkbox"/> Train employee	
<input type="checkbox"/> Train supervisor	
<input type="checkbox"/> No Action Practical	
<input type="checkbox"/> Other _____	

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 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

**WORKER'S AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH
INFORMATION FOR WORKERS' COMPENSATION PURPOSES (HIPAA COMPLIANT)**

I, (Print Worker's Name) _____, hereby authorize the health care provider (HCP) – (the name of HCP is optional and not required for release of medical information) (Print Health Care Provider's Name) _____ the use or disclosure of my health information as described in this authorization.

1. **INFORMATION** WCA No. _____

Date of Birth _____ Date of Injury _____ SSN _____

Address _____ Phone _____

Worker's representative, if any: _____ Phone _____

Address: _____

2. **RELEASE**

I authorize the Health Care Provider (HCP) or any member or employee of its office or association who has examined or treated me, as well as any hospital or treatment facility in which I have been a patient, to disclose and release complete and legible copies of any and all information concerning my physical or psychiatric condition, care and treatment, to my employer, _____ Sandoval County _____, and/or its insurance carrier, _____ NMAC _____, and/or their attorneys, and/or duly authorized representatives of the New Mexico Workers' Compensation Administration and its current medical cost containment contractor or their duly authorized agents. Copies of all documentation released pursuant to this authorization shall be sent to the agency requesting the information and to me or my representative as listed above.

3. I understand the following information will be released pursuant to a work-related/occupational injury or illness/workers' compensation claim: medical reports; clinical notes; nurses' notes; patient's history of injury; subjective and objective complaints; x-rays; test results; interpretation of x-rays or other tests (including a copy of the report); diagnosis and prognosis; hospital bills; bills for services the HCP has rendered; payments received; and any other relevant and material information in the HCP's possession. This Authorization also includes, if applicable, any hospital operational logs, emergency logs, tissues committee reports, psychiatric reports and records, physical therapy records, and all outpatient records. This release may also be used to request a Form Letter to HCP as approved by the Workers' Compensation Administration. I understand that I have the right to restrict the information that may be provided by signing this authorization to the extent provided by law.

CONDITIONS

4. I understand the purpose of this request is to determine the proper level of workers' compensation benefits and may include information regarding any of the following: to determine my occupational injury or illness status; to determine my eligibility for workers' compensation benefits; to determine my current and future medical status after occupational injury; to determine my current medical status and/or return-to-work capability.

5. Right to revoke: I understand I have the right to revoke this authorization at any time by notifying the company named in Paragraphs 1 and 2. I understand that the revocation is only effective after it is received and logged by that company and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation. I further understand that my revocation of this authorization may affect my ability to receive occupational injury or workers' compensation benefits governed by this revocation.

6. I understand that after this information is disclosed, the recipient may continue to use it pursuant to my prior authorization, regardless of my subsequent revocation of this authorization. I further understand that different protections may be available pursuant to state and federal law.

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization Yes No - If Yes, I have received a copy _____ (initial)
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee

Date

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): _____

Signature of Personal Representative

Date

**NMCIA WORKERS' COMPENSATION
CLAIM EXPLANATION**

In reporting this alleged on-the-job injury/occupational illness, which occurred on [redacted] 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 county's internal loss prevention procedures and the New Mexico Workers' Compensation Act. [redacted] (Initials)

2. Reporting the injury/illness does not automatically qualify me for Workers' Compensation benefits. [redacted] (Initials)

3. This injury/illness will be investigated by my County and NMCIA, who will determine if the injury/illness qualifies under the guidelines of the Workers' Compensation Act. [redacted] (Initials)

4. I will be advised by proper authority if particular investigative circumstances or facts 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, I am aware that I may contact the New Mexico Workers Compensation Administration for information and/or assistance. [redacted] (Initials)

5. 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. I am fully aware that unauthorized treatment may not be a covered workers' compensation benefit. [redacted] (Initials)

(Check one)

My employer chooses to select the health care provider for the first 60 days **X**
My employer will permit me to select the health care provider for the first 60 days

6. My supervisor or a designated HR representative will be promptly informed of all doctor's appointments, diagnosis/prognosis, billings and/or changes in treatment. [redacted] (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-job injury/illness will be subject to any disciplinary or possible law enforcement actions.

[redacted]
Print name of employee

[redacted]
Signature of employee

[redacted]
Date

NMCIA WORKERS' COMPENSATION BENEFITS EXPLANATION

I, [REDACTED], 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. [REDACTED] (initials)

2. The workers' compensation benefit is computed at 66% 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. [REDACTED] (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 counties share of such deductions, unless the employee applies, and is approved for, leave under the Family and Medical Leave Act (FMLA). [REDACTED] (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. [REDACTED] (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 county for the amount of overpayment received. In return, the county must reinstate the applicable amount of sick and/or annual leave used during the first week. [REDACTED] (initials)

6. The amount of overpayment will be computed by the county 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. [REDACTED] (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

Workers' Name: _____

DOB: _____

SSN:*-**-** _____

Claim Number: _____

AUTHORIZATION TO COMMUNICATE DIRECTLY WITH HCP

I authorize communication between my Health Care Provider (HCP) and the adjuster, employer, medical case manager, attorney, or other representatives of my employer and its insurance carrier to discuss issues without me being present that pertain to my accident/injury, causation, return to work status or additional medical care that may be requested.

MY DECISION TO SIGN OR NOT SIGN THIS FORM DOES NOT AFFECT ANY BENEFITS THAT MAY BE DUE.

Worker's signature: _____

Date: _____

Witness to signature: _____

Date: _____

Trabajadores Nombre: _____

DOB: _____

SSN: *-**-** _____

Demanda Número: _____

AUTORIZACIÓN A COMUNIQUÉSE DIRECTAMENTE CON HCP

Autorizo la comunicación en medio mi abastecedor del cuidado médico (HCP) y el ajustador, patrón, encargado médico del caso, abogado, u otros representantes de mi patrón y de su portador de seguro a discuta las ediciones sin mí que es presente que pertenecen a mi accident/injury, causalidad, vuelta al estado del trabajo o asistencia médica adicional que pueden ser solicitado.

MI DECISIÓN A LA MUESTRA O NO FIRME ESTA FORMA NO AFECTE CUALQUIER VENTAJA ESA PUEDE SER DEBIDO.

Firmade Worker's: _____

Fecha: _____