YOUR LOGO HERE

**WORKERS’ COMPENSATION PROCEDURES & GENERAL INFORMATION PACKET**

PLEASE SUBMIT TO:

**Your department address & contact information here**

**Address**

**Address**

**Telephone Number**

**Contact.Person@YourSchool.com**

In order to be eligible for Workers’ Compensation benefits for work-related injuries or occupational illnesses, employees must adhere to the following Workers’ Compensation Procedures.

* **Report injury or illness to (name of appropriate department) and Supervisor, Principal, or Nurse IMMEDIATELY.** Report can be made via phone call, email, and/or Supervisor’s Accident Investigation Report (attached; page 4)
	+ Reporting injury/illness to a coworker is not considered proper notice
	+ The Workers’ Compensation Act requires a worker to report every accident to their supervisor within 15 days of occurrence*.* NMPSIA requests that all work-place injury/illnesses are reported within 24 hours and no later than 72 hours after injury/illness in accordance with New Mexico Workers’ Compensation Rules.
* **Submit Notice of Accident or Occupational Disease Disablement** (attached; page 5) to **(name of appropriate department)** as soon as possible.
	+ **(Name of your school) does NOT direct medical care involving Workers’ Compensation claims.** Employees are allowed to seek medical care from a physician of their choosing.
	+ The health care provider must accept Workers’ Compensation Insurance. It is the employee’s responsibility to verify before continuing care.
	+ **(Name of your school)** and CCMSI retain the right to change health care provider after 60 days, if they feel it is necessary.
* **Submit NMWCA Employer’s First Report of Injury or Illness** (attached; page 6) to **(name of appropriate department)** as soon as possible.
* **Submit NMWCA Worker’s Authorization for Use & Disclosure of Health Records** (attached; page 7)
	+ The employee provides permission for CCMSI and **(name of your school)** to obtain specific health records.
* **Employee must provide copies of any & all physician documentation, including work restrictions, to (name of appropriate department)**
	+ **NMWCA Provider’s Report of Physical Ability** (attached; page 8-9)
		- To be filled out by the treating physician to determine work status/restrictions unless HCP chooses to use a different format
	+ Employees are responsible for following health care provider’s medical instructions/ restrictions
		- Return-To-Work restrictions must be reviewed and approved by the **(name of appropriate department)** before the employee can return to work.
		- If necessary, a Modified Job Duty Offer must be signed before employee can return to work.

**Other Important Information:**

* All documentation will be submitted to CCMSI, our third party administrator for Workers’ Compensation, where claim acceptance or denial will be decided after review.

* If employee misses work because of a work-related injury/illness, Workers’ Compensation will provide indemnity pay at a rate of 66 2/3% of employee’s regular pay based on a 29-week wage history, on the 8th consecutive calendar day of lost time.
	+ After the 28th day of lost time, the employee will be paid for the first 7 days.
	+ In the event that the employee is out of work, all leave (sick, personal, and annual) will be exhausted to continue your pay from LCPS at 100%.
		- **The employee must contact Payroll Department at (list telephone number) to verify the amount of leave accrued/used.**
			* If the employee is out of work for more than 7 days and all leave has been exhausted, employee will receive Workers’ Compensation checks at 66 2/3% of normal salary. Checks will be sent directly to employee via USPS.
			* If employee is out of work for more than 7 days and leave has **not** been exhausted, Workers’ Compensation checks must be signed over to LCPS.
				+ Checks will be sent directly to the employee via USPS and the employee must turn them in to **(name of appropriate department)**.
* For absences that extend past 5 days, employee must contact the **(name of appropriate department)**

**Employee (Please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Name of appropriate department)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_