How to Fill Out a Notice of Accident Form

What to do after you've been injured at work

STATE OF NEW MEXICO
Workers' Compensation Administration

Notice of Accident Forms Exist Because Workplace Injuries and Illnesses Happen

- Sometimes accidents happen
- The workers' compensation system does not look to blame the worker OR the employer
- The form is a way to help you through the process

The Notice of Accident Form

The Workers' Compensation Administration (WCA) provides a Notice of Accident Form to be filled out when someone is injured or becomes ill on the job.

The Worker **must** report the accident/injury to the Employer **within 15 days** using the Notice of Accident form (NOA). This is the law. §52-1-29 NMSA 1978

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/*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: **Worker will choose health care provider. Yes___ No___**
Completado por el empleador: *Trabajador elegirá proveedor de atención médica.*
If Yes, Employer has right to change health care provider after 60 days. **If No, Worker 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 dias. *En caso que no elige, el trabajador tiene derecho a cambiar de proveedor de atención médica después de 60 dias.*
WORKER'S INITIALS ____ *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

Form NOA-1 **Employer/employee: Each keep one copy.** **Empleador/empleado: Retener una copia.** **----SEE BACK OF THIS FORM---- ----VER AL REVERSO DE ESTA FORMA--**

Where Can I Find the Form?

- Look in your break room
- Is there a poster nearby?
- Ask your employer
- Or contact a WCA ombudsman

- The box in the poster's center notes the Employer's claims administrator. This is the person who can help you with your injury claim, once filed.

State of New Mexico Workers' Compensation Administration

WORKERS' COMPENSATION ACT

If You Are Injured At Work
Si Se Lastima En El Trabajo

1) **Notice** -- In most cases you must tell your employer about the accident within 15 days, using the Notice of Accident Form.

2) **You have the right** to information and assistance from an information specialist known as an Ombudsman at the Workers' Compensation Administration.

3) **Claims information** -- Contact your employer's Claims Representative.

1) **Aviso.** -- En la mayoría de los casos usted debe de avisarle a su empleador del accidente dentro de los primeros 15 días usando las formas de Aviso de Accidente.

2) **Usted tiene el derecho** a información y ayuda contactándose con un especialista en información conocido como "Ombudsman" en la Administración para la Compensación a los Trabajadores.

3) **Información acerca de Reclamaciones.** -- Contáctese con el representante de reclamaciones de su compañía.

Employer's Insurer / Claims Representative:

Name: ____________________
Phone #: ____________________
Address: ____________________

Note: Employer must fill in this insurer / claims representative information.

YOUR RIGHTS

If you are injured in a work-related accident:

Your employer / insurer must pay all reasonable and necessary medical costs.

You may or may not have the right to choose your health care provider. If your employer / insurer has not given you written instructions about who chooses first, call an ombudsman. In an emergency, get emergency medical care first.

If you are off work for more than 7 days, your employer / insurer must pay wage benefits to partially offset your lost wages.

If you suffer "permanent impairment," you may have the right to receive partial wage benefits for a longer period of time.

SUS DERECHOS

Si se lastima en el trabajo:

Su empleador / asegurador debe de pagar por los gastos médicos necesarios y razonables.

Es posible que usted tenga, o no tenga, el derecho de escoger el proveedor de servicios para la salud. Si su empleador / asegurador no le ha dado instrucciones por escrito de quien es él que selecciona primero, pregúntele o llame a un ombudsman. En una emergencia, obtenga asistencia médica de emergencia primero.

Si usted está fuera del trabajo por más de siete días, su empleador / asegurador debe de hacerle un pago compensatorio de prestaciones para compensar parcialmente la pérdida de su salario.

Si usted sufre "daño permanente," usted puede tener el derecho a recibir prestaciones parciales de salario por un periodo de tiempo más largo.

Ombudsmen are located at the following offices:
Albuquerque: 1-800-255-7965, 1-505-841-6000 | Farmington: 1-800-568-7310, 1-505-599-9746 | Las Cruces: 1-800-870-6826, 1-505-524-6246 | Las Vegas: 1-800-281-7889, 1-505-454-9251 | Lovington: 1-800-934-2450, 1-505-396-3437

If You Need HELP Call:
Ask for an Ombudsman
Si Usted Necesita Ayuda Llame Al:
Pregunte por un Ombudsman
1-866-WORKOMP (1-866-967-5667)
Visit our website at: www.state.nm.us/wca

For FREE copies of this poster and Notice of Accident Forms call: 1-866-967-5667

USE A NOTICE OF ACCIDENT FORM TO REPORT YOUR ACCIDENT TO YOUR SUPERVISOR

EMPLOYER: You are required by law to post this poster where your employees can read it and to post Notice of Accident forms with it. This poster without Notice of Accident forms does not comply with law. You have other rights and duties under the law.

New Mexico Workers' Compensation Administration
2410 Centre Avenue, Albuquerque, New Mexico 87106
P.O. Box 27198, Albuquerque, New Mexico 87125-7198

POST FORMS HERE

This poster published 5/15/03. It remains valid until reissued and supersedes all prior versions except 12/23/02. Previous posters will be treated as compliant until 12/31/03.

How to Fill Out the Form

- Either the worker or employer can fill out the form. If the worker is unable to fill out the form, a supervisor may be able to help.
- Fill in the name of the person injured.
- The form asks for information on the accident. What day did it occur? What time? Where?
- The worker will need to state their social security number.
- Describe what happened.
- The worker will need to sign the form.
- The Employer fills out the shaded area and signs the form as well.
- Both worker and employer get a copy of the form once it is filled out.

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Use the Back of the NOA Form

- On the form's reverse side, you'll find information that may be of help. If you have difficulty filling out the form, or have questions, contact us—toll free—at 1-866-WORKOMP/1-866-967-5667.
- The form lists the number of our offices statewide.
- The WCA's web address is also listed.

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 dias 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
Hobbs: (575) 397-3425 - 1 (800) 934-2450
Las Cruces: (575) 524-6246 - 1 (800) 870-6826
Las Vegas: (505) 454-9251 - 1 (800) 281-7889
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe: (505) 476-7381

Rev. 11/18

https://workerscomp.nm.gov

Thank You!

Ombudsman Hotline: 1-866-967-5667

STATE OF NEW MEXICO

Workers' Compensation Administration

ONE TEAM | ONE GOAL

A Better New Mexico for Workers and Employers