AR 11-03

AMENDING AN ADMINISTRATIVE REGULATION INITIATING AND REGULATING THE REPORTING OF ACCIDENTS INVOLVING CITY EMPLOYEES AND/OR PROPERTY DAMAGE

Section 1. Purpose

The attached forms have been updated and are designed to facilitate accurate and timely communication between the City department staff, the City Manager's office, Risk Management and the Human Resources Department relating to worker's comp and liability insurance requirements.

Section 2. Submitter Requirements

Any City employee involved in a property damage incident or accident, whether injuries are involved or not, shall be required to submit a completed Notice of Accident form, Incident/Accident Report. All written documentation shall be submitted to the employee's supervisor in a timely fashion in order for the supervisor to submit the employee's documentation as well as the Supervisor's Incident/Accident Report **within 24 hours** of the accident to Human Resources and the Risk Manager's Office. The supervisor is also responsible for obtaining a copy of any law enforcement report of the accident/incident and submit to Human Resources and Risk Manager's Office as soon as the report is available.

Injuries requiring medical attention are to be reported to the Human Resources Office immediately. If the injury is of a severe nature requiring immediate medical attention, the Human Resources Office must be notified as soon as possible thereafter.

In addition, **all incidents** involving a City vehicle and/or equipment are to be reported to the Human Resources representative or Human Resources Director **immediately.** Authorization for drug and/or alcohol screening can only be given by the Human Resources Director, Risk Manager, City Manager, or his designee.

Section 3: Discipline

Failure to abide by this Administrative Regulation may subject the employee and/or the supervisor to the following discipline:

1st incident - written reprimand
2nd incident - 2 days without pay
3rd incident - 5 days without pay
4th incident- termination

This Administrative Regulation and all attached forms supercedes AR 03-02.

Eric Honeyfield, City Manager

8-11-11
Date

I acknowledge that I was provided a copy of and read this policy:

Employee

Date

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/*la(s) hora(s)*) *el* (date/*fecha*) *del 20____*

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

What happened? _____
¿Qué ocurrió?

_____

_____

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

Date _____ Date: _____
Fecha: *Fecha:*

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

Worker --
For emergency medical care, go to any emergency medical facility
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 through Friday, 8 a.m. to 5 p.m., except holidays.

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

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
Las Cruces: (575) 524-6264 - 1 (800) 870-6826
Las Vegas (505) 454-9251 - 1 (800) 281-7389
Lovington: (575) 396-3437 - 1 (800) 934-2450
Roswell: (575) 623-3997 - 1(866) 311-8587
Santa Fe (505) 476-7381
TDD for the deaf: (505) 841-6043
www.workerscomp.state.nm.us

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

Form NOA-1-W (4/11)

EMPLOYEE'S INCIDENT/ACCIDENT REPORT

(To be completed by the employee only)

Employee's Name _____ Employee's SSN _____

Address _____ Phone _____

Date of Accident: _____ Time of Accident: _____ [ ] am [ ] pm

Name of Supervisor: _____

When was Supervisor Notified: Date: _____ Time: _____ [ ] am [ ] pm

Location of Accident: _____

Describe in detail what occurred. (What were you doing? Identify location, all conditions, equipment, materials, chemicals, actions and individuals that contributed to the accident).

_____

_____

_____

_____

_____

Did accident result in an injury to you? Yes [ ] No [ ]

Describe the injury (be specific about body part(s) affected):

_____

_____

_____

_____

_____

Do you require medical treatment: Yes [ ] No [ ]

If yes, contact Human Resources (575-397-9230)

If yes name of supervisor who authorized treatment: _____

Clinic referred to: _____

Accident caused by anyone not employed by the City? Yes [ ] No [ ]
If yes, give name, address, and phone number:

_____

_____

Did accident result in injury to a non – employee? Yes [ ] No [ ]
If yes, give name, address, and phone number:

_____

_____

What do you consider the real and basic cause of this accident? (Be specific and detailed)

_____

_____

_____

_____

What should be done to prevent similar accidents?

_____

_____

_____

_____

_____

_____ _____

Employee's Signature Date

SUPERVISOR'S INCIDENT/ACCIDENT INVESTIGATION REPORT

(To be completed by the employee's supervisor or other responsible administrative official)

Name of Employee Involved: _____

Name of Supervisor: _____ Supervisor's Phone Number: _____

Accident: Personal Injury _____ Property Damage _____

Date of Accident: _____ Time of Accident: _____ [ ] am [ ] pm

Work Schedule: Days of Week: _____
Starting Time: _____ Ending Time: _____

Did the employee promptly report the incident/accident to you? Yes [ ] No [ ]

Location of Accident: _____

Is location of accident within employee's work area? Yes [ ] No [ ]
If no, explain:

What was employee doing when incident/accident occurred?

What machines, tools, equipment, etc. were being used?

Was this incident/accident job related: Yes [ ] No [ ]
If no, explain:

Were safeguards or safety equipment provided? Yes [ ] No [ ]
If no, explain:

Was employee wearing personal protective equipment? Yes [ ] No [ ]
If yes, PPE worn:

What do you consider the real and basic cause of this accident? (Be specific and detailed)

What should be done to prevent similar accidents?

Was this accident preventable? Yes [ ] No [ ]

Provide additional comments/recommendation:

Supervisor's signature

Date

EMPLOYEE
PROPERTY DAMAGE REPORT

(To be completed by the employee & person investigating)

(This section to be completed by the employee)

Employee's Name _____

Was any City of Hobbs property damaged? Yes [ ] No [ ]
If yes, have person investigating complete this form. If no, sign and date below.

_____ _____
Employee's Signature Date

(This section to be completed by person investigation incident/accident)

CITY EMPLOYEE INVOLVED

Name _____ Phone _____

Employee's Job_____ Driver's license No._____

CITY PROPERTY INVOLVED

City Vehicle: Year & Make_____ Type_____City Unit #_____

City Department_____ City Vehicle License #_____

Other City Property (What property was damaged):_____

_____

Description of the Damage to City Property: _____

_____

Cost of Repair or Replacement: $_____ Damage Appraised By: _____

Damage Due To: [ ] Traffic Accident [ ] Other _____

OTHER PARTIES INVOLVED

Was there another party involved? Yes [ ] No [ ]

Owner's Name	Address	Phone
Driver's Name	Address	Phone

Driver's License # _____ State: _____

Vehicle: Year & Make _____ Type: _____ License # _____

Insurance Agency: _____ Address: _____

Insurance Company: _____ Police Number: _____

Other Property (Description of property that was damaged): _____

Description of Damage to Vehicle or Property: _____

Provide additional comments/recommendations: _____

If traffic accident, was a citation issued?

[ ] City Employee Violation # _____
[ ] Other Party Violation # _____
[ ] No Citation Issued

Investigated By _____ Date _____

Reviewed By _____ Date _____

WITNESS STATEMENT

(To be completed by the employee & witness)

(This section to be completed by the employee)

Employee's Name _____

Did anyone witness the incident/accident? Yes [ ] No [ ]
If yes, have each witness complete a witness statement. If no, sign below)

_____ _____
Employee's Signature Date

(This section to be completed by incident/accident witness)

Name of Witness:_____ Phone:_____

Job Title of Witness:_____ Supervisors Name: _____

Date of Accident: _____ Time of Accident:_____ [ ] am [ ] pm

Location of Accident: _____

Describe how accident occurred: (including events that occurred immediately before the accident):

_____

_____

_____

_____

Describe bodily injury sustained (be specific about body part(s) affected):

_____

_____

_____

_____

_____

_____ _____
Witness Signature Date

Revised 12-01-10

EXPOSURE REPORT

(To be completed by the employee)

(This section to be completed by the employee)

Employee's Name _____

Where you exposed to any chemicals, bodily fluids, airborne diseases, etc? Yes [ ] No [ ]
If yes, continue completing this form. If no, sign below)

_____ _____
Employee's Signature Date

Employee's SSN _____ Date of Exposure: _____

Time of Exposure:_____ [ ] am [ ] pm Duration of Exposure: _____

Name and Type of Exposure: _____

Description of Exposure (be specific):

_____

_____

_____

_____

Symptoms (if any are present):

_____

_____

_____

_____

Do you wish to go for a baseline blood draw: Yes [ ] No [ ]
If yes contact Human Resources (575-397-9230).

_____ _____
Employee's Signature Date

_____ _____
Supervisor's Signature Date

Revised 12-01-10