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## In this newsletter: What to do when an employee is injured on the job

### About those surge protectors...

A source for lots of different types is [newegg.com/Product/ProductList.aspx](http://newegg.com/Product/ProductList.aspx). They have protectors with 6 and 7 foot cords, and up to 12 outlets. Many brands. Don't use old protectors. at the Med School. All injuries involving electric shock should be evaluated by a doctor. Ensure the employee receives the required medical treatment.

Test and flow eyewashes.

Worker's compensation pays for all authorized medical treatment and compensates the employee for lost wages at 66-2/3% of computed wages.

After medical care, make sure forms are filed in a timely basis. Contact Workers' Compensation Specialist within 24 hours of incident. Ensure that a First Report of Accident is completed. Forward the report to UNM Safety & Risk Services Department.

Communicate with the injured employee and Workers' Compensation Department

The employee should notify his/her supervisor *when the injury occurs*. The employee should complete a Notice of Accident (half page form), NOA-1.

The employee should complete an UNM First Report of Accident Report, WCA E1.1, *as soon as possible, but no later than 15 days*. This form is provided by the EOHS clinic, or the Risk Management office. The supervisor should forward the report to UNM Safety & Risk Services *within 24 hours of receipt*.

**Be sure the Worker's Compensation Act, "IF YOU ARE INJURED AT WORK" poster is displayed in work areas, bulletin boards, and places where employees frequent. It is important to have this poster in an clearly visible.**

The first page of the WCA E1.1 is included in this message. The entire form is found on our website <http://shea.unm.edu/forms.html>. They are available from the Risk Management office and the EOHS clinic, and require the supervisor to make comments and sign the form.



FIRST REPORT OF ACCIDENT—WCA E1.1

RETURN TO: UNM RISK MANAGEMENT DEPARTMENT  
ONATE HALL, Room 137

The University of New Mexico

THIS FORM TO BE COMPLETED BY EMPLOYEE AND HIS/HER SUPERVISOR

1. Name of Employer UNIVERSITY OF NEW MEXICO				2. Department name			
3. Department mailing address				4. Department phone # ( ) ( )		5. Employee work phone # ( ) ( )	
6. Name: Last First Middle			7. Male <input type="checkbox"/>	Female <input type="checkbox"/>	8. Social security # - -		9. Employee home phone # ( ) ( )
10. Home Address				11. City or town		12. State	13. Zip Code
14. Date of birth		15. Age	16. Marital status <input type="checkbox"/> Married <input type="checkbox"/> Single/Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Unknown			17. No. of children under 18 yrs.	
18. Date hired	19. No. of hours worked/day	20. No. of days worked/week	21. Normal starting time : <input type="checkbox"/> AM <input type="checkbox"/> PM		22. Average earnings: hour week bi-week month year \$ PER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
23. Date of injury	24. Time of injury : <input type="checkbox"/> AM <input type="checkbox"/> PM	25. First date unable to work	26. Was injured paid in full for this day? <input type="checkbox"/> YES <input type="checkbox"/> NO		27. Did injury occur on employer's premises? <input type="checkbox"/> YES <input type="checkbox"/> NO		
28. Where did accident, illness, or exposure occur?				29. City or town		30. State	31. Zip Code
32. Occupation when injured		33. Were these normal duties? <input type="checkbox"/> YES <input type="checkbox"/> NO		34. If no, describe normal duties			
35. If occupational illness, date of diagnosis		36. Estimated time of work From To		37. Date employee returned to work		38. If fatal, date of death	
39. Describe in detail how the injury/illness occurred and what the employee was doing when the injury/illness occurred.							
40. Identify objects/substances which directly injured the employee (e.g. machine, vapor, poison, radiation, chemical, etc.)							
41. Describe the nature of the injury or disease in detail and indicate the part of the body affected (e.g. amputation, broken bone, inhalation, etc.)							
42. Name, address and phone number of witness(es)							
43. Name & address of physician treating injury/illness				44. Name & address of hospital or facility where treated			

DO NOT WRITE  
IN THIS COLUMN

Org code
Job code
Location code
Entered by
Date entered

PLEASE COMPLETE REVERSE SIDE.  
FORM MUST BE COMPLETED ON BOTH SIDES.