WORKERS' COMPENSATION
CLAIM EXPLANATION

In reporting this alleged on-the-job injury/occupational illness, which occurred on _____.
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 agency's internal loss prevention procedures and the New Mexico Workers' Compensation Act. _____
(Initials)
2. Reporting the injury/illness does not automatically qualify me for Workers Compensation benefits. _____
(Initials)
3. 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/illness. I am fully aware that unauthorized treatment may not be a covered Workers' Compensation benefit.

   My employer requires me to select the health care provider for the first 60 days.

   _____ _____
   (Name of Physician) (Employee Signature)

4. This injury will be investigated by my agency and Risk Management Division, who will determine if the injury/illness qualifies under the guidelines of the Workers' Compensation Act. _____
(Initials)
5. I will be advised by proper authority if particular investigative circumstances or facts **AT THE AGENCY LEVEL** 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 at the agency level, I am aware that I may request reconsideration of my claim by the assigned Workers Compensation Claims Administrator at Risk Management Division at (505) 827-0232. _____
(Initials)
6. My supervisor or a designated agency representative (_____) will be promptly informed of all doctors' appointments, diagnosis/prognosis, billings and/or changes in treatment. _____
(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-the job injury/illness will be regarded as falsification of official documents.

_____ _____
Print name of Employee Print name of witness

_____ _____
Signature of Employee Signature of witness

_____ _____
Date Date