

**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 employer'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. This injury/illness will be investigated by my employer and Risk Management Division, who will determine if the injury/illness qualifies under the guidelines of the Workers' Compensation Act. _____Initials
4. I will be advised by proper authority if particular investigative circumstances or facts at the NMSU 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 NMSU 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
5. 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. I am fully aware that unauthorized treatment may not be a covered Workers' Compensation benefit. _____Initials

My employer chooses to select the health care provider for the first 60 days. _____
(for Las Cruces area employees only) Initials

6. My supervisor or designated employer representative **Benefit Services** 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-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