

**STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION**

_____, WCA No.: _____
Worker,
v. _____, and
_____,
Employer/Insurer.

NOTICE OF ACCEPTANCE OR REJECTION OF RECOMMENDED RESOLUTION

YOU MUST FILE THIS NOTICE WITHIN THIRTY (30) DAYS OF YOUR RECEIPT OF THE RECOMMENDED RESOLUTION OR THE RECOMMENDED RESOLUTION WILL BECOME FINAL AND BINDING.

1. (Name of the party filing this notice): _____
gives notice the Recommended Resolution of the Mediator is:

Accepted

Rejected

2. The Recommended Resolution is rejected because:

Signature Date

Name of filing party

Address

City/State/Zip

Telephone

E-mail address for service

I hereby certify that a true copy of the foregoing has been mailed to all parties on _____, 20____.

Signature