STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

APPLICATION TO DIRECTOR

1. Type of injury: ☐ Accidental Work Injury ☐ Occupational Disease
2. Worker's full name: _____
   Mailing address: _____
   City/State/Zip: _____
   Telephone: _____
   Worker's date of birth: _____ Age: _____ Sex: ☐ M ☐ F
   Worker's social security no.: _____
3. Full name of employer: _____
   Employer's address: _____
   City/State/Zip: _____
   Telephone: _____
   Email address for service: _____
4. Insurance carrier: _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____
   E-mail address for service: _____
5. Health Care Provider (*if applicable*): _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____

6. Date of accident or death: _____

   City and county of accident: _____

   Nature of the injury: _____

   Worker's job at time of accident:_____

   Weekly compensation rate: _____

7. What benefit or relief is being sought?

   ☐ Judge assignment disputes, pursuant to, Sections 52-5-2 NMSA 1978, and 52-5-5, and NMAC 11.4.4.13(A).

   ☐ Hearing on an untimely rejection of a recommended resolution, pursuant to, Section 52-5-5 NMSA 1978.

   ☐ Request to withdraw an acceptance of a recommended resolution, pursuant to Section 52-5-5 NMSA 1978,

   ☐ Appointment of Recipient of Benefits on behalf of a minor child or incompetent worker, pursuant to, Section 52-5-11 NMSA 1978 and 11.4.4.11 NMAC..

   ☐ Approval of an out of state health care provider (affidavit of provider shall be attached), pursuant to Section 52-4-1 NMSA 1978 and 11.4.7.10.NMAC.

   ☐ Attorney withdrawal, pursuant to 11.4.4.14 NMAC.

   ☐ WCA case management or utilization review dispute, pursuant to Sections52-4-2 NMSA 1978 and 52-4-3, and 11.4.7.12 NMAC.

   ☐ Other (specify):

8. State all reasons supporting this application (be specific; use additional pages, if necessary):

9. Is a hearing requested? ☐ Yes ☐ No

If yes, the filing party shall submit the mandatory forms. Request for Setting and with the Summons, if applicable.

10. Is an interpreter needed for the hearings on this application? ☐ Yes ☐ No

If yes, what language? _____
(Employer will pay for cost of interpreter.)

_____ _____

Signature Date Print name

_____
Filing party's address

_____
Filing party's city, state, zip

_____
Filing party's telephone

_____
Filing party's e-mail address for service

INSTRUCTIONS FOR USE: A Request for Setting and a Summons for each responding party shall be filed with the application, if a summons has not been previously issued. If the Worker is filing this application, the Worker shall also attach Worker's Authorization for Use and Disclosure of Health Records.

Parties with questions may call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.