STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

APPLICATION TO WORKERS' COMPENSATION JUDGE

1. Type of injury: ☐ Accidental Work Injury ☐ Occupational Disease
2. Worker's Full Name: _____
3. Mailing Address: _____
   City/State/Zip: _____
   Telephone: _____
   E-mail Address for service: _____
   Worker's highest level of school completed: _____
   Worker's date of birth: _____ Age: _____ Sex: ☐ M ☐ F
   Worker's Social Security No.: _____
4. Full Name of Employer: _____
   Employer's Address: _____
   City/State/Zip: _____
   Telephone: _____
   Email Address for service: _____
5. Insurance Carrier: _____
   Address: _____
   City/State/Zip: _____
   Telephone: _____
   E-mail Address for service: _____
6. Date of Accident: _____
   City and County of accident: _____
   How did the accident occur: _____
   Nature of the injury: _____

Part(s) of the body injured: _____

First date Worker was unable to perform job duties: _____

7. Worker's job at time of accident: _____

   Worker's average weekly wage: _____

   Weekly compensation rate: _____

8. Doctor's Name: _____

   Mailing Address: _____

   City/State/Zip: _____

   Telephone: _____

9. Doctor who set the maximum medical improvement: _____

   Date of maximum medical improvement: _____

   Impairment rating: _____ Date assessed: _____

   Has Worker been released to work by a Doctor? ☐ Yes ☐ No
   If yes, please indicate the date Worker was released to work: _____

   Has Worker returned to work since the accident? ☐ Yes ☐ No
   If yes, please indicate the date Worker returned to work: _____

10. Current Employer's Name: _____

    Mailing Address: _____

    City/State/Zip: _____

11. Is an interpreter needed for the hearings on this application? ☐ Yes ☐ No
    If yes, what language? _____
    (Employer will pay for cost of interpreter.)

12. THIS APPLICATION SEEKS THE FOLLOWING RELIEF**:** (check all that apply)

    ☐ Physical Examination of Worker pursuant to Section 52-1-51 NMSA 1978

    ☐ Independent Medical Examination pursuant to Section 52-1-51 NMSA 1978

    ☐ Approval of Stipulated Reimbursement Agreement under Section 52-5-17 NMSA 1978

    ☐ Supplemental Compensation Order

    ☐ Consolidation of payments into quarterly payments (not a lump sum under Section 52-5-12 NMSA 1978)

    ☐ Determination of: ☐ Bad Faith/Unfair Claims Processing ☐ Fraud or ☐ Retaliation

    ☐ Attorney Fees, Amount: $ _____

    ☐ Limited Discovery/Approval of Communication with HCP

    ☐ Court Ordered Release of Medical Records

    ☐ Other:

13. Why is this application being filed? (Be specific, use additional pages, if necessary.)

_____ _____

Filing Party signature Date Attorney's signature Date

_____ _____

Print name Print name

_____

Filing party /attorney's address

_____

Filing party /attorney's city, state, zip

_____

Filing party /attorney's telephone

_____

Filing party / attorney's e-mail address for service

INSTRUCTIONS: 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.