

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

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

WORKER'S RESPONSE

Worker responds to Employer/Insurer's ____ **Complaint** and/or ____ **Application to Judge** (check all that apply):

- I was hurt on the job.
- I am disabled.
- I have not returned to work.
- My doctor has not released me to return to work.
- Employer has not provided work within my restrictions.
- I gave notice of the accident to my employer within 15 days of the accident.
- Employer has not provided adequate medical care.
- The statute of limitations does not bar my entitlement to weekly benefits.
- A causal link between my disability and accident has been shown to a reasonable degree of medical probability.
- Other:

Signature Date

Print name

Address

City/State/Zip

Telephone

E-mail address for service