STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

WORKER'S RESPONSE TO COMPLAINT

Worker, _____, responds to Employer/Insurer's Complaint as indicated (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

_____
Print name

_____
Address

_____
City/State/Zip

_____
Telephone

_____
E-mail address for service