

**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 medical case management or utilization review dispute, pursuant to Sections 52-4-2 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.