

**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.*

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

\_\_\_\_\_, WCA No.: \_\_\_\_\_  
Worker,  
v. \_\_\_\_\_, and  
\_\_\_\_\_,  
Employer/Insurer.

**SUMMONS FOR APPLICATION TO WORKERS' COMPENSATION JUDGE**

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GREETINGS:**

You are directed to file a written response with the Clerk of the Workers' Compensation Administration **within 15 days of receipt of this Application.**

If you do not file and serve a responsive pleading or motion, the Workers' Compensation Administration may enter a judgment against you for the relief demanded in the Application.

Worker or filing party's representative:  
\_\_\_\_\_  
Address of Worker or filing party's representative:  
\_\_\_\_\_  
\_\_\_\_\_

**WITNESSED AND SEALED BY THE CLERK OF THE WCA**

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

\_\_\_\_\_, WCA No.: \_\_\_\_\_  
Worker,  
v. \_\_\_\_\_, and  
\_\_\_\_\_,  
Employer/Insurer.

**REQUEST FOR SETTING**

1. WCA Judge assigned: \_\_\_\_\_
2. Are any other hearings currently set?  Yes  No  
If yes, please indicate the date of the hearing: \_\_\_\_\_
3. Specific matter to be heard: \_\_\_\_\_
4. Time required for hearing: \_\_\_\_\_
5. Is an interpreter required?  Yes  No  
(Employer/Insurer is responsible for making arrangements for the interpreter.)
6. Is telephonic appearance being requested?  Yes  No  
(Employer/Insurer is responsible for arranging the conference call.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
E-mail address for service

**NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION  
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS**

Worker/Patient FULL NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: XXX-XX-\_\_\_\_\_

FOR WCA REFERENCE ONLY: Date/s of Injury: \_\_\_\_\_ WCA Case File Number: \_\_\_\_\_

**INSTRUCTIONS FOR USE:** In accordance with Section 52-10-1 NMSA 1978, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any work place injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed \$1.00 per page for the first ten (10) pages or up to twenty-cents (\$.20) for each page thereafter. A copy of this authorization may be used as an original.  
***Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman (866) 967-5667.***

**RELEASE OF HEALTH CARE RECORDS**

I, (Worker's Name) \_\_\_\_\_, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility:	
Address:	
Telephone No.:	

I authorize the following records released (check box, as appropriate):  **ALL RECORDS**  **SPECIFIC DATES**  
provide a date range for records authorized to be released \_\_\_\_\_

**RELEASE OF SPECIFIC HEALTH RECORDS**

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (check any that may apply).

- Treatment for alcohol and/or substance abuse       Sexually transmitted diseases       HIV or AIDS  
 Behavioral or Mental Health, including Psychiatric or Psychological       Records of the Department of Health Medical Cannabis Program

\_\_\_\_\_  
Signature of Worker/Patient/Personal Representative

\_\_\_\_\_  
Date

**PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS**

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be  Picked Up  Mailed  Emailed  Faxed  Other (specify): \_\_\_\_\_

Authorized Recipient/s:	
Address:	
Telephone No.:	
Fax/Email:	

**EXPIRATION and  
CONDITIONS**

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

\_\_\_\_\_  
Signature of Worker/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Personal Representative (if any)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Relationship to Worker/Patient