**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print name

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City/State/Zip

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 Telephone

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 E-mail address for service