

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: _____
Mailing Address: _____
City/State/Zip: _____
Telephone No.: () _____
3. Worker's date of birth: / / Age: ____ Sex: ____ M ____ F ____
4. Worker's Social Security No.: ____ - ____ - ____
5. Full Name of Employer: _____
Employer's Address: _____
City/State/Zip: _____
Telephone No.: () _____
6. Insurance Carrier: _____
Address: _____
City/State/Zip: _____
Telephone No.: () _____
7. Date of Accident: _____
a. City and County of accident: _____
b. Worker's job at time of accident: _____
c. Worker's average weekly wage: _____
d. Weekly compensation rate: _____
e. How did the accident occur: _____
f. Nature of the injury: _____
g. Part(s) of the body injured: _____
h. Name and address of treating Doctor(s): _____
i. First date Worker was unable to perform job duties: _____
j. Date of maximum medical improvement: _____
k. Impairment rating: _____ Date assessed: _____
Doctor's Name: _____
l. Has Worker been released to work by a Doctor? ___ Yes ___ No [check one]
If yes, please indicate the date Worker was released to work: _____
m. Has Worker returned to work since the accident? ___ Yes ___ No [check one]
If yes, please indicate the date Worker returned to work: _____
n. Name and address of current Employer: _____
o. Highest level of school completed by Worker: _____
8. a. This application seeks the following relief:
_____ Physical Examination of Worker
_____ Independent Medical Examination
_____ Approval of Stipulated Reimbursement Agreement under Section 52-5-17
_____ Supplemental Compensation Order
_____ Consolidate payments into quarterly payments (not a lump sum under Section 52-5-12)
_____ Determination of: ___ Bad Faith/Unfair Claims Processing ___ Fraud or
_____ Retaliation

_____ Attorney Fees, Amount: \$ _____
b. Why is this application being filed? (Be specific, use additional pages, if necessary.)

9. Is an interpreter needed for the hearings on this application? ___ Yes ___ No.
If yes, what language? _____ Worker will not be responsible for cost.

Worker's Signature

Attorney's Signature

Date

Worker/Attorney's Name

Worker/Attorney's Address

Worker/Attorney's City, State, Zip

Worker/Attorney's Telephone & Fax Number

A Summons for each adverse party shall be filed with the application if one has not been previously filed. If Worker is filing this application, an Authorization to Release Medical Information form shall be filed with the application for Physical Examination of Worker or Independent Medical Examination only.

If you have questions, please call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.