

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.

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____,
Worker,

WCA No.: _____

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 10 days of receipt of this Application**, and to mail a copy of the response to the filing party within the same time period.

You are notified that, unless you serve and file 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 CLERK OF THE WCA

(SEAL)

By: _____

Date: _____

(EACH RESPONDING PARTY MUST BE NAMED IN THE SUMMONS)

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. Names/addresses/phone & fax of all counsel/parties pro se entitled to notice:

NOTICE OF HEARING

This matter will be heard before Judge _____ on _____,
20____, at _____ a.m./p.m. with _____ hours/minutes allocated for hearing

at: (____) WCA Office or (____) _____
2410 Centre Ave SE _____
Albuquerque, NM 87106 _____
(505) 841-6000 _____

By: Calendar Clerk

Notice Mailed _____, 20____, by _____
Counsel are expected to appear:

(____) in person (____) by telephone conference call.

STAMPED ENVELOPES FOR ALL PARTIES MUST BE SUBMITTED WITH REQUEST

7. I understand that information to be released pursuant to a work-related/occupational injury or illness/workers' compensation claim may also be released to WCA and its current medical cost containment contractor or their duly authorized agents.

8. I hereby expressly waive any regulations and/or rules of ethics that might otherwise prevent any hospital, health care provider or other person who has treated me or examined me in a professional capacity from releasing such records.

9. A photostatic or other copy of this Release, which contains my signature, shall be considered as effective and valid as the original, and shall be honored by those to whom it is sent or provided for a period of six (6) months from the date it was signed.

10. This Release does not authorize any personal or telephonic conferences or correspondence directly between any health care provider and a representative of my employer, its attorney or insurance carrier to discuss my case and is solely for the release of medical documentation as set forth herein. Brief communication for the limited purpose of obtaining medical records is permitted.

11. I understand I am entitled to a copy of this authorization and to any records provided hereunder. I am requesting a copy of this authorization Yes No - If Yes, I have received a copy _____ (initial)
I understand this authorization will expire within six (6) months of the date I signed it, unless I revoke it earlier, pursuant to Paragraph 5.

Signature of Employee _____ **Date** _____

Personal Representative Section:

If a personal representative executes this form, that representative warrants that he or she has authorization to sign this form on the basis of (print detailed basis for representation): _____
_____.

Signature of Personal Representative _____ **Date** _____