STATE OF NEW MEXICO

WORKERS' COMPENSATION ADMINISTRATION

____________________________________, WCA No.:_________________
Worker,
v.
____________________________________, and

____________________________________,
Employer/Insurer.

WORKERS' COMPENSATION COMPLAINT

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 Number: _______-______-_______
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. What benefit or relief is being sought?
      1. Complaints by Worker:
      ___Temporary Total Disability ___Death Benefits
      ___Permanent Total Disability ___Attorney Fees
      ___Permanent Partial Disability ___Disfigurement
      ___Safety Device Increase (name device):______________________________
      ___Mental Impairment: ___Primary ___Secondary

___Medical Benefits (list here or attach unpaid bills: ____
_____ Determination of: ____Bad Faith/Unfair Claims Processing _____Fraud or ____Retaliation
___Other (specify):____

2. Complaints by Employer:
___Determination of Compensability/Benefits
___Safety Device Decrease (name device):_______________________________________
___Reimbursement Right
___Credit for Overpayment
___Suspension or Reduction of Benefits (state grounds):________________________________
____
Other (specify):____

b. State all reasons supporting this complaint (be specific; use additional pages, if necessary):
____
____

9. Is an interpreter needed for the hearings on this complaint? ___Yes ___ No.
If yes, what language? ______________________________. If yes, Employer must furnish.
If you have questions, call 1-800-255-7965, Mediation Bureau.

10. Medicare Eligibility:
a. Is Worker a current Medicare beneficiary? ___ Yes ___ No
b. Has Worker applied for Social Security Disability benefits in the past 5 years? ___ Yes___ No
c. Has Worker been diagnosed with End Stage Renal Disease? ___ Yes ___ No
(*See* 42 USC 426-1)

______________________________	______________________________
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 and insurer shall be filed with the Complaint. If the Worker is filing this Complaint, an Authorization to Release Medical Information form shall be filed with the Complaint.