

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

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

**PETITION FOR LUMP SUM PAYMENT**  
**RETURN TO WORK**

This form should be used for lump sums after return to work for 6 months, earning at least 80% of the pre-injury wage pursuant to §52-5-12(B).

1. Type of injury:      \_\_\_ Occupational 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 wages at time of accident: \$\_\_\_\_ hour \$\_\_\_\_ bi-weekly \$\_\_\_\_ month \$\_\_\_\_ year
  - d. How did the accident occur: \_\_\_\_\_
  - e. Part(s) of the body injured: \_\_\_\_\_
  - f. Type of injury/diagnosis: \_\_\_\_\_
  - g. Name and address of treating Doctor(s): \_\_\_\_\_
  - h. First date Worker was unable to perform job duties: \_\_\_\_\_
  - i. Date of maximum medical improvement: \_\_\_\_\_
  - j. Impairment rating: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_
  - k. Has Worker been released to work by a Doctor? \_\_\_Yes\_\_\_No  
If yes, indicate the date Worker was released to work: \_\_\_\_\_
  - l. Has Worker returned to work since the accident?      \_\_\_Yes\_\_\_No  
If yes, indicate the date Worker returned to work: \_\_\_\_\_
  - m. Name and address of current Employer: \_\_\_\_\_
  - n. Highest level of school completed by Worker: \_\_\_\_\_
8.
  - a. Average weekly wage: \_\_\_\_\_
  - b. Weekly compensation rate: \_\_\_\_\_
  - c. Disability rating, if known: \_\_\_\_\_
9.
  - a. The Worker returned to work on \_\_\_\_\_, 20\_\_\_\_. (Relevant wage records should be attached and must be provided at hearing.)

- b. The Worker returned to \_\_\_\_\_ the same job; \_\_\_\_\_ modified job duties; or \_\_\_\_\_ other job duties; or \_\_\_\_\_ other situation applies. Please explain: \_\_\_\_\_.
  - c. Worker's income \_\_\_\_\_ is; \_\_\_\_\_ is not at least 80% of the pre-injury average weekly wage. If not, explain: \_\_\_\_\_
10. A request is made for approval of a lump sum payment as follows:
- a. A lump sum payment of weekly compensation benefits in the amount of: \_\_\_\_\_.
  - b. The lump sum payment of weekly compensation benefits is a lump sum of all remaining weekly payments. Medical benefits shall not be affected under the terms of this lump sum payment.
  - c. Is a discount being taken? If yes, state the percentage and amount: \_\_\_\_\_
  - d. Attorney fees in the amount of \$\_\_\_\_\_, including gross receipts tax.
  - e. Other: \_\_\_\_\_
11. Is an interpreter needed for the hearings on this petition? \_\_\_Yes \_\_\_No.  
If yes, what language? \_\_\_\_\_ Worker will not be responsible for cost.

**IF THE VERIFICATION IS NOT SIGNED BY THE WORKER, THE PETITION WILL NOT BE ACCEPTED FOR FILING BY THE WCA CLERK OF THE COURT.**

**VERIFICATION OF THE WORKER**

I, \_\_\_\_\_, Worker, verify I have read this petition for lump sum payment return to work. In accordance with NMRA 1-011(B), I swear and affirm under penalty of perjury under the laws of the State of New Mexico that this petition is true and correct and that I understand the terms and conditions of the lump sum settlement payment. I understand approval of this petition will affect my future entitlement to workers' compensation benefits.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Worker's signature

\_\_\_\_\_  
Signature of Worker's Attorney (if any)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone & Fax Number

\_\_\_\_\_  
E-mail address (optional)

A Summons for each adverse party shall be filed with the petition if one has not been previously filed. If you have questions, please call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.

**A HEARING BEFORE AND APPROVAL BY A WORKERS' COMPENSATION JUDGE IS REQUIRED BEFORE THE LUMP SUM AGREEMENT CAN BECOME EFFECTIVE. A REQUEST FOR SETTING, PROPOSED ORDER AND SELF-ADDRESSED STAMPED ENVELOPES FOR ALL PARTIES ENTITLED TO NOTICE MUST BE SUBMITTED WITH THIS PETITION OR IT WILL NOT BE ACCEPTED FOR FILING BY THE WCA CLERK OF THE COURT.**

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

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

**PETITION FOR PARTIAL LUMP SUM PAYMENT FOR DEBTS**

This form should be used for a partial lump sum advance for payment of debts accumulated during the course of the disability pursuant to §52-5-12 (C). Attach documentation indicating the date debt was incurred, name, address and phone number of the creditor, payment amount currently due and total balance.

1. Type of injury:      \_\_\_ Occupational 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 wages at time of accident: \$\_\_\_\_ hour \$\_\_\_\_ bi-weekly \$\_\_\_\_ month \$\_\_\_\_ year
  - d. How did the accident occur: \_\_\_\_\_
  - e. Part(s) of the body injured: \_\_\_\_\_
  - f. Type of injury/diagnosis: \_\_\_\_\_
  - g. Name and address of treating Doctor(s): \_\_\_\_\_
  - h. First date Worker was unable to perform job duties: \_\_\_\_\_
  - i. Date of maximum medical improvement: \_\_\_\_\_
  - j. Impairment rating: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_
  - k. Has Worker been released to work by a Doctor? \_\_\_Yes\_\_\_No  
If yes, indicate the date Worker was released to work: \_\_\_\_\_
  - l. Has Worker returned to work since the accident?      \_\_\_Yes\_\_\_No  
If yes, indicate the date Worker returned to work: \_\_\_\_\_
  - m. Name and address of current Employer: \_\_\_\_\_
  - n. Highest level of school completed by Worker: \_\_\_\_\_
8.
  - a. Average weekly wage: \_\_\_\_\_
  - b. Weekly compensation rate: \_\_\_\_\_
  - c. Disability rating, if known: \_\_\_\_\_
9. This form should be used for approval of a partial lump sum advance for debts as follows:
  - a. A lump sum advance of weekly compensation benefits in the amount of: \_\_\_\_\_.

- b. The lump sum advance of weekly compensation benefits is a portion of remaining weekly payments. If a partial lump sum is approved, as of the \_\_\_\_ day of \_\_\_\_, 20\_\_\_\_, the Worker will have \_\_\_\_\_ weeks of weekly compensation benefits remaining.
  - c. Medical benefits shall not be affected by the terms of this lump sum advance for debts.
  - d. The parties are seeking an award or approval of attorney fees in the amount of \$\_\_\_\_\_, including gross receipts tax.
  - e. Other: \_\_\_\_\_
10. Is an interpreter needed for the hearings on this petition? \_\_\_Yes \_\_\_No.  
If yes, what language? \_\_\_\_\_ Worker will not be responsible for cost.

**IF THE VERIFICATION IS NOT SIGNED BY THE WORKER, THE PETITION WILL NOT BE ACCEPTED FOR FILING BY THE WCA CLERK OF THE COURT.**

**VERIFICATION OF THE WORKER**

I, \_\_\_\_\_, Worker, verify I have read this petition for partial lump sum payment for debts. In accordance with NMRA 1-011(B) I swear and affirm under penalty of perjury under the laws of the State of New Mexico that this petition is true and correct and that I understand the terms and conditions of the lump sum settlement payment. I understand approval of this petition will affect my future entitlement to workers' compensation benefits. I hereby certify that I have incurred debts in the amount of \$\_\_\_\_\_ during the period of disability.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Worker's signature

\_\_\_\_\_  
Signature of Worker's Attorney (if any)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone & Fax Number

\_\_\_\_\_  
E-mail address (optional)

A Summons for each adverse party shall be filed with the petition if one has not been previously filed. If you have questions, please call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.

**A HEARING BEFORE AND APPROVAL BY A WORKERS' COMPENSATION JUDGE IS REQUIRED BEFORE THE LUMP SUM AGREEMENT CAN BECOME EFFECTIVE. A REQUEST FOR SETTING AND SELF-ADDRESSED STAMPED ENVELOPES FOR ALL PARTIES ENTITLED TO NOTICE MUST BE SUBMITTED WITH THIS PETITION OR IT WILL NOT BE ACCEPTED FOR FILING BY THE WCA CLERK OF THE COURT.**

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

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

**JOINT PETITION FOR LUMP SUM SETTLEMENT**

This form should be used to request a lump sum settlement pursuant to §52-5-12 (D). In order to use this form, the parties must agree to the settlement and sign this joint petition. By filing this joint petition the parties are submitting to the jurisdiction of the Workers' Compensation Administration. This form should not be used for return to work or partial lump sum for debt. Please note: This settlement may be affected by federal Medicare regulations if benefits for future medical care are affected.

1. Type of injury: \_\_\_\_\_ Occupational 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 wages at time of accident: \$ \_\_\_\_ hour \$ \_\_\_\_ bi-weekly \$ \_\_\_\_ month \$ \_\_\_\_ year
  - d. How did the accident occur: \_\_\_\_\_
  - e. Part(s) of the body injured: \_\_\_\_\_
  - f. Type of injury/diagnosis: \_\_\_\_\_
  - g. Name and address of treating Doctor(s): \_\_\_\_\_
  - h. First date Worker was unable to perform job duties: \_\_\_\_\_
  - i. Date of maximum medical improvement: \_\_\_\_\_
  - j. Impairment rating: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_
  - k. Has Worker been released to work by a Doctor? \_\_ Yes \_\_ No  
If yes, indicate the date Worker was released to work: \_\_\_\_\_
  - l. Has Worker returned to work since the accident? \_\_ Yes \_\_ No  
If yes, indicate the date Worker returned to work: \_\_\_\_\_
  - m. Name and address of current Employer: \_\_\_\_\_
  - n. Highest level of school completed by Worker: \_\_\_\_\_
8.
  - a. Average weekly wage: \_\_\_\_\_
  - b. Weekly compensation rate: \_\_\_\_\_
  - c. Disability rating, if known: \_\_\_\_\_
9.
  - a. The proposed settlement is (\_\_\_\_) Total (\_\_\_\_) Partial.

- b. The proposed settlement is by agreement and is undisputed by the parties? \_\_\_Yes \_\_\_No  
10. Is an interpreter needed for the hearings on this petition? \_\_\_Yes \_\_\_No.  
If yes, what language? \_\_\_\_\_ Worker will not be responsible for cost.

**IF THE VERIFICATION IS NOT SIGNED BY THE WORKER, THE PETITION WILL NOT BE ACCEPTED FOR FILING BY THE WCA CLERK OF THE COURT.**

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

**VERIFICATION OF THE WORKER**

I, \_\_\_\_\_, Worker, verify I have read this petition for lump sum settlement approval. In accordance with NMRA 1-011(B), I swear and affirm under penalty of perjury under the laws of the State of New Mexico that this petition is true and correct and that I understand the terms and conditions of the lump sum settlement agreement. I understand approval of this agreement will affect my future entitlement to workers' compensation benefits.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Worker's signature

\_\_\_\_\_  
Signature of Worker's Attorney (if any)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone & Fax Number

\_\_\_\_\_  
E-mail address (optional)

**APPROVAL OF THE EMPLOYER/INSURER/OTHER (UNDISPUTED PETITIONS)**

I, \_\_\_\_\_, Employer/Insurer/Attorney, state that I have read this petition for lump sum settlement approval, that I sign this Joint Petition with full authority to do so, and I confirm that I understand the terms and conditions of the lump sum settlement agreement. I understand approval of this agreement will affect my company's/client's obligation to pay under this settlement and its future obligation to pay workers' compensation benefits.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone & Fax Number

\_\_\_\_\_  
E-mail address (optional)

**A HEARING BEFORE AND APPROVAL BY A WORKERS' COMPENSATION JUDGE IS REQUIRED BEFORE THE LUMP SUM AGREEMENT CAN BECOME EFFECTIVE. A REQUEST FOR SETTING, PROPOSED ORDER AND SELF-ADDRESSED STAMPED ENVELOPES FOR ALL PARTIES ENTITLED TO NOTICE MUST BE SUBMITTED WITH THIS PETITION OR IT WILL NOT BE ACCEPTED FOR FILING BY THE WCA CLERK OF THE COURT.**

**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**

**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 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)**