

STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.: _____
Worker,
v. _____, and
_____,
Employer/Insurer.

RESPONSE

Employer, by and through Attorney/Representative _____, responds to Worker's complaint as indicated (check all that apply):

1. ___ The Worker was not hurt on the job.
2. ___ The Worker is not disabled.
3. ___ Actual or written notice of the accident was not received within ___ days.
4. ___ Employer has provided adequate medical care.
5. ___ The Worker has not complied with the law regarding the selection of a health care provider.
6. ___ The statute of limitations bars the Worker's complaint for weekly compensation benefits.
7. ___ A causal link between disability and accident has not been shown to a reasonable medical probability.
8. ___ The Worker sustained a scheduled injury.
9. ___ (Other): _____

I certify a copy of the Response was mailed to each opposing party this date

(Signature of Party mailing Response.)

Signature

Attorney/Representative

Address

City/State/Zip
(___)_____ (___)_____
Telephone & Fax Number