

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

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

**WORKER'S RESPONSE TO COMPLAINT**

Worker, \_\_\_\_\_, responds to Employer/Insurer's Complaint as indicated (check all that apply):

1.     \_\_\_ I was hurt on the job.
2.     \_\_\_ I am disabled.
3.     \_\_\_ I have not returned to work.
4.     \_\_\_ My doctor has not released me to return to work
5.     \_\_\_ Employer has not provided work within my restrictions.
6.     \_\_\_ I gave notice of the accident to my employer within 15 days of the accident.
7.     \_\_\_ Employer has not provided adequate medical care.
8.     \_\_\_ The statute of limitations does not bar my entitlement to weekly benefits.
9.     \_\_\_ A causal link between my disability and accident has been shown to a reasonable degree of medical probability.
10.    \_\_\_ (Other): \_\_\_\_\_  
          \_\_\_\_\_  
          \_\_\_\_\_

I certify a copy has been [ ] mailed [ ] faxed  
to opposing party on (date): \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
(Signature of party mailing response)

\_\_\_\_\_  
Signature  
\_\_\_\_\_  
Print Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City/State/Zip  
( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
Telephone & Fax Number