

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

_____, WCA No.: _____
 Worker
 vs
 _____ and
 Employer
 _____,
 Insurer

APPLICATION TO WORKERS' COMPENSATION JUDGE

1. Type of injury: (check one)	<input type="checkbox"/> Occupational Injury	<input type="checkbox"/> Occupational Disease	
2. Worker's Full Name: _____			
Mailing Address: _____			
City/State/Zip: _____			
Telephone No.: () - _____			
3. Worker's date of birth: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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 wages at time of accident:	\$ /hour	\$ /month	\$ /year
d. How did the accident occur? _____			
e. Nature of injury: _____			
f. Part(s) of the body injured: _____			
g. Name and address of treating Doctor: _____			
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate the date Worker was released to work:	/ /
l. Has Worker returned to work since the accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please indicate the date Worker returned to work:	/ /
m. Name and address of current Employer:	
n. Highest level of school completed by Worker:	

8. A. This application seeks the following relief:

<input type="checkbox"/> Physical Examination of Worker			
<input type="checkbox"/> Independent Medical Examination			
<input type="checkbox"/> Supplemental Compensation Order			
<input type="checkbox"/> Determination of:	<input type="checkbox"/> Bad Faith/Unfair Claims Processing	<input type="checkbox"/> Fraud	<input type="checkbox"/> Retaliation
<input type="checkbox"/> Attorney Fees:	Amount \$		
:			
<input type="checkbox"/> Other (specify):			

B. Why is this application being filed? (Be specific; use additional pages, if necessary.)

_____		_____	
Filing Party's Name		Attorney/Representative's Name & Address	
_____		_____	
Signature	Date	Attorney/Representative'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.