STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____________________________________, WCA No.:_______________
Worker,

v.

_____________________________________, and

_____________________________________,
Employer/Insurer.

JOINT PRE-LITIGATION REPORT

(This document is intended to inform the Court and assist the parties in identifying the areas of dispute prior to additional discovery. The initial filing party is to initiate work on this document.)

A. STIPULATIONS/ADMISSIONS –Check the box indicating agreement to the stipulation.

	E/I Agrees	Worker Agrees	
1.			Accident/s occurred on _________________.
2.			Accident/s was in the course of employment.
3.			Accident/s arose out of and was incident to employment.
4.			Notice (actual or written) was received within 15 days of accident/s.
5.			Worker's s average weekly wage was $_________.
6.			Workers' s compensation rate at the time of their accident was $________ per week.
7.			Worker has not received any benefits for their alleged accident of ____.
8.			Worker's job, at the time of accident was ____.
9.			The DOT Code for Worker's job was: __________________. The O*Net Code for Worker's job was: _________________. * Self represented parties may skip.

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	E/I Agrees	Worker Agrees	
10.			Worker's jobs for the last 10 years consist of:
11.			Worker's date of birth is _________________.
12.			The highest grade level completed by Worker is _________________.
13.			Medical care was originally selected by Employer/Insurer.
14.			Non-emergency medical care was first provided on _______________.
15.			Unpaid medical bills are from ___________________ in the amount of $ _______.
16.			Worker suffered an injury to their ____________________ as a result of the accident.
17.			Worker has reached MMI. MMI occurred _________________.
18.			Worker has not reached MMI.
19.			Worker has been released to return to work. Release occurred on _________________.
20.			Worker has not been released to return to work.
21.			Employer offered work to Worker.
22.			Employer has not offered work to Worker since they ceased working on _________________.
23.			Worker has been assigned the following impairment rating/s: ____.
24.			Impairment was assessed by ___________________________, M.D. on _________________.

	E/I Agrees	Worker Agrees	
25.			Worker has returned to work. Worker's wage is $________ per week.
26.			Worker did not lose time from work.
27.			Other

B. RECITAL OF CONTESTED ISSUES - (Check all that apply)

___ Temporary Total Disability
___ Temporary Partial Disability
___ Scheduled Injury Benefits
___ Future Medicals
___ Safety Device Rate Modification
___ Other
___ Permanent Total Disability
___ Permanent Partial Disability
___ Past Medicals
___ Return to Work with Employer
___ Attorney Fees

C. NAMES, ADDRESS AND TELEPHONE NUMBERS OF AUTHORIZED HCPs.

Name	**Address**	**Phone Number**

D. WITNESSES

(If medical causation is at issue, causation **must** be established through expert testimony.)
(DEPOSITION/FORM LETTER) of an authorized health care provider)

Worker may call:

Name	Expected to testify to:

Employer/Insurer may call:

Name	Expected to testify to:
______________________________	____
______________________________	____
______________________________	____
______________________________	____
______________________________	____

E. DISPUTED DISCOVERY PROCEDURES

Worker:

Employer/Insurer:

F. OTHER MATTERS

The possibility of settlement of this case is considered: ___Yes ___ No

Would a settlement conference be helpful? ___Yes ___ No

G. REPRESENTATION

The Worker is represented by: ___________________________

The Employer / Insurer is represented by: ___________________________

________________________________	________________________________
Worker	Employer / Insurer