STATE OF NEW MEXICO
WORKERS' COMPENSATION ADMINISTRATION

_____, WCA No.:_____
Worker,

v.

_____, and

_____,
Employer/Insurer.

APPLICATION TO WORKERS' COMPENSATION JUDGE

1. Type of injury: ☐ Accidental Work Injury ☐ Occupational Disease
2. Worker's Full Name: _____
3. Mailing Address: _____

   City/State/Zip: _____

   Telephone: _____

   E-mail Address for service: _____

   Worker's highest level of school completed: _____

   Worker's date of birth: _____ Age: _____ Sex: ☐ M ☐ F

   Worker's Social Security No.: _____
4. Full Name of Employer:_____

   Employer's Address: _____

   City/State/Zip: _____

   Telephone: _____

   Email Address for service: _____
5. Insurance Carrier: _____

   Address:_____

   City/State/Zip: _____

   Telephone: _____

   E-mail Address for service: _____
6. Date of Accident: _____

   City and County of accident: _____

   How did the accident occur: _____

   Nature of the injury: _____

Part(s) of the body injured: _____

First date Worker was unable to perform job duties: _____

7. Worker's job at time of accident: _____

   Worker's average weekly wage: _____

   Weekly compensation rate: _____

8. Doctor's Name: _____

   Mailing Address: _____

   City/State/Zip: _____

   Telephone: _____

9. Doctor who set the maximum medical improvement: _____

   Date of maximum medical improvement: _____

   Impairment rating: _____ Date assessed: _____

   Has Worker been released to work by a Doctor? ☐ Yes ☐ No
   If yes, please indicate the date Worker was released to work: _____

   Has Worker returned to work since the accident? ☐ Yes ☐ No
   If yes, please indicate the date Worker returned to work: _____

10. Current Employer's Name: _____

    Mailing Address: _____

    City/State/Zip: _____

11. Is an interpreter needed for the hearings on this application? ☐ Yes ☐ No
    If yes, what language? _____
    (Employer will pay for cost of interpreter.)

12. THIS APPLICATION SEEKS THE FOLLOWING RELIEF**:** (check all that apply)

    ☐ Physical Examination of Worker pursuant to Section 52-1-51 NMSA 1978

    ☐ Independent Medical Examination pursuant to Section 52-1-51 NMSA 1978

    ☐ Approval of Stipulated Reimbursement Agreement under Section 52-5-17 NMSA 1978

    ☐ Supplemental Compensation Order

    ☐ Consolidation of payments into quarterly payments (not a lump sum under Section 52-5-12 NMSA 1978)

    ☐ Determination of: ☐ Bad Faith/Unfair Claims Processing ☐ Fraud or ☐ Retaliation

    ☐ Attorney Fees, Amount: $ _____

    ☐ Limited Discovery/Approval of Communication with HCP

    ☐ Court Ordered Release of Medical Records

    ☐ Other:

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

_____ _____

Filing Party signature Date Attorney's signature Date

_____ _____

Print name Print name

_____

Filing party /attorney's address

_____

Filing party /attorney's city, state, zip

_____

Filing party /attorney's telephone

_____

Filing party / attorney's e-mail address for service

INSTRUCTIONS: Request for Setting and a Summons for each responding party shall be filed with the application, if a summons has not been previously issued.

If the Worker is filing this application, the Worker shall also attach Worker's Authorization for Use and Disclosure of Health Records.

Parties with questions may call the Ombudsman Hotline at 505-841-6894 or 1-866-967-5667.

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 15 days of receipt of this Application**.

If you do not file and serve 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 THE CLERK OF THE WCA

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. Is an interpreter required? ☐ Yes ☐ No
   (Employer/Insurer is responsible for making arrangements for the interpreter.)
6. Is telephonic appearance being requested? ☐ Yes ☐ No
   (Employer/Insurer is responsible for arranging the conference call.)

_____
Signature

_____
Print name

_____
Address

_____
City/State/Zip

_____
Telephone

_____
E-mail address for service

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION
WORKER'S AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH RECORDS

Worker/Patient FULL NAME: _____ DOB: _____ SSN: XXX-XX-_____

FOR WCA REFERENCE ONLY: Date/s of Injury: _____ WCA Case File Number: _____

INSTRUCTIONS FOR USE: In accordance with Section 52-10-1 NMSA 1978, a workers' compensation health care provider shall not require a signed medical authorization, in any form, for records that are directly related to any workplace injuries or disabilities claimed by an injured worker. Costs for copying records are subject to non-clinical services fees set by the Administration, and shall not exceed $1.00 per page for the first ten (10) pages or up to twenty-cents ($0.20) for each page thereafter. A copy of this authorization may be used as an original.

Este formulario es obligatorio al presentar una queja. Si necesitas ayuda para completar este formulario, póngase en contacto con un ombudsman (866) 967-5667.

RELEASE OF HEALTH CARE RECORDS

I, (Worker's Name) _____, hereby authorize the following health care provider (HCP) or named facility to release my health care records for the **PURPOSE OF** facilitating and evaluating my Worker's Compensation Claim that arises from alleged workplace injuries or illnesses that occurred on the above date/s of injury.

Provider or Facility:		
Address:		
Telephone No.:		

I authorize the following records released (check box, as appropriate): ☐ **ALL RECORDS** ☐ **SPECIFIC DATES**

provide a date range for records authorized to be released _____

RELEASE OF SPECIFIC HEALTH RECORDS

I FURTHER AUTHORIZE THE RELEASE OF RECORDS THAT MAY CONTAIN INFORMATION ABOUT THE FOLLOWING: (check any that may apply).

☐ Treatment for alcohol and/or substance abuse ☐ Sexually transmitted diseases ☐ HIV or AIDS

☐ Behavioral or Mental Health, including Psychiatric or Psychological ☐ Records of the Department of Health Medical Cannabis Program

_____ _____

Signature of Worker/Patient/Personal Representative Date

PERSON/ENTITY AUTHORIZED TO RECEIVE RECORDS

I authorize records be released to my employer, my employer's insurer, my attorney or representative, my employer/insurer's attorney or representative, and IME providers.

(To be completed by authorized recipient/s): Records to be ☐ Picked Up ☐ Mailed ☐ Emailed ☐ Faxed ☐ Other (specify):

_____

Authorized Recipient/s:		
Address:		
Telephone No.:		
Fax/Email:		

EXPIRATION and CONDITIONS

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN IT AND SUCH A REFUSAL TO SIGN MAY NOT AFFECT MY TREATMENT OR SERVICES, EXCEPT AS PERMITTED BY LAW. THIS AUTHORIZATION IS LIMITED TO USE AND DISCLOSURE OF MEDICAL RECORDS AND DOES NOT WAIVE ANY PATIENT DOCTOR PRIVILEGE WITHOUT MY SEPARATE AUTHORIZATION AND CONSENT. THIS AUTHORIZATION IS TO BE VALID FOR TWO (2) YEARS FROM THE DATE OF MY SIGNATURE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECIPIENT/S. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE HEALTH CARE PROVIDER OR FACILITY IN WRITING; A COPY OF ANY REVOCATION SHOULD BE PROVIDED TO THE RECIPIENT/S. UPON MY REQUEST, I AM ENTITLED TO A COPY OF THE SIGNED AUTHORIZATION.

_____ _____

Signature of Worker/Patient Date

_____ _____

Signature of Personal Representative (if any) Date

_____ _____

Printed Name of Personal Representative Relationship to Worker/Patient

Rev. 8/22
11.4.4.9 NMAC