

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

\_\_\_\_\_ , WCA No.: \_\_\_\_\_  
 Worker  
 vs  
 \_\_\_\_\_ and  
 Employer  
 \_\_\_\_\_ ,  
 Insurer

**WORKERS' COMPENSATION COMPLAINT**

<b>1. Type of injury:</b> (check one)	<input type="checkbox"/> Occupational Injury			<input type="checkbox"/> Occupational Disease		
<b>2. Worker's Full Name:</b>						
Mailing Address:						
City/State/Zip:						
Telephone No.: ( ) -						
<b>3. Worker's date of birth:</b>	/	/	Age:	Sex:	<input type="checkbox"/> M	<input type="checkbox"/> F
<b>4. Worker's Social Security No.:</b> - -						
<b>5. Full Name of Employer:</b>						
Employer's Address:						
City/State/Zip:						
Telephone No.: ( ) -						
<b>6. Insurance Carrier:</b>						
Address:						
City/State/Zip:						
Telephone No.: ( ) -						
<b>7. Date of Accident:</b> / /						
<b>a. City and County of accident:</b>						
<b>b. Worker's job at time of accident:</b>						
<b>c. Worker's wages at time of accident:</b>			\$ /hour	\$ /month	\$ /year	
<b>d. How did the accident occur?</b>						
<b>e. Part(s) of the body injured:</b>						
<b>f. Type of injury:</b>						
<b>g. Name and address of treating Doctor:</b>						
<b>h. First date Worker was unable to perform job duties</b>				/	/	
<b>i. Date of maximum medical improvement:</b>				/	/	
<b>j. Impairment rating:</b>			<b>Doctor's Name:</b>			
<b>k. Has Worker been released to work by a Doctor?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please indicate the date Worker was released to work:				/	/	

1. 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:

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n. Highest level of school completed by Worker:

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**8. A. What benefit or relief is being sought?**

1. Complaints by Worker:

<input type="checkbox"/> Temporary Total Disability	<input type="checkbox"/> Death Benefits
<input type="checkbox"/> Permanent Total Disability	<input type="checkbox"/> Attorney Fees
<input type="checkbox"/> Permanent Partial Disability	<input type="checkbox"/> Disfigurement

Safety Device Increase (name device):

<input type="checkbox"/> Mental Impairment:	<input type="checkbox"/> Primary	<input type="checkbox"/> Secondary
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Medical Benefits (list here or attach unpaid bills):

Other (specify):

2. Complaints by Employer:

Determination of Compensability/Benefits

Safety Device Decrease (name device):

Reimbursement Right

Credit for Overpayment

Suspension or Reduction of Benefits (state grounds):

Claim Against Subsequent Injury Fund (state basis for claim):

Other (specify):

**B. State all reasons supporting this complaint (be specific; use additional pages if necessary):**

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9. Is an interpreter needed for the hearings on this complaint?  Yes  No

***If yes, Employer must furnish. If you have questions, call 1-(800) 255-7965, Mediation Bureau.***

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.***