

**New Mexico Workers' Compensation Administration  
Report to the Enforcement Bureau**

Name of Party Suspected of Wrongdoing: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

If Individual: SSN: \_\_\_\_\_ DOB or Age \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer's Phone #: \_\_\_\_\_ Address: \_\_\_\_\_  
City, State Zip: \_\_\_\_\_

This person/organization is a:  Worker  Employer  Insurance Agency  Case Manager  
 Insurance Carrier  Claims Adjuster  Health Care Provider  Attorney For Insurer  
 attorney for worker  other (describe) \_\_\_\_\_

Why do you suspect a wrongful act is being committed?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach/send in any documentation, pictures, etc.

Has this matter been heard/scheduled to be heard in mediation or formal hearing?  Yes  No

If Yes, WCA Case #: \_\_\_\_\_

INFORMATION ABOUT YOU

Relationship to Above Named Party:  Worker  Employer  Insurance Carrier  Attorney  
 Other Gov./Law Enforcement Agency  Department of Insurance  Health Care Provider  
 Anonymous  Friend, Neighbor or Relative of Subject  WCA Employee

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

May we use your name? \_\_\_\_\_ Are you willing to assist at a later date? \_\_\_\_\_  
Have you called before? \_\_\_\_\_ Are you willing to testify in court if needed? \_\_\_\_\_