RISK MANAGEMENT DIVISION
DOCTOR VISIT/MODIFIED WORK ASSIGNMENT

EMPLOYEE IS TO RETURN THIS COMPLETED FORM TO HIS/HER EMPLOYER AT THE CONCLUSION OF EACH AND EVERY DOCTOR VISIT

DATE _____ EMPLOYER_____

DOCTOR _____ SOCIAL SECURITY#_____

_____

_____ is a State of New Mexico _____ Department Employee. An alleged on the job injury was reported by this employee on _____ which may require treatment, as you determine. Please complete the data below so that a claim may be processed by the Risk Management Division.

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