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| STATE OF COLORADO |  |
| OFFICE OF ADMINISTRATIVE COURTS |
| 1525 Sherman Street, Denver, CO 80203 |
|  |  |  |
| Claimant, |
|  | 🟂 **COURT USE ONLY** 🟂 |
| vs. | **WC NUMBER:** |
|  |  |  |  |  |  |
| Employer, and |  |
|  |  |  | **DATE OF INJURY:** |
| Respondent. |  |  |  |
| **RESPONSE TO**  |  | APPLICATION FOR HEARING |
|  | Date of Application for Hearing |  |
|  |  |  |  |  |
| **A.** | **Response to Application for Hearing**: | Filed by or for |  | (Print Name of Party) |
|  |  |  |  |
| In addition to the issues marked on the Application for Hearing, the following issues shall be considered at the hearing: |
|  |
|  |  | Compensability |  |  |  | Temporary Total Benefits from |
|  |  |  |  |  |  |
|  |  | Medical Benefits |  | to |  | Ongoing  |
|  |  | Authorized provider |  |  |  |
|  |  | Reasonably necessary |  |  | Temporary Partial Benefits from |  |
|  |  |  |  |  |  |
|  |  | Average Weekly Wage |  | to |  | Ongoing |
|  |  |  |  |  |  |
|  |  |  |  |
|  |  | Petition to Reopen Claim |  |  | Permanent Partial Disability Benefits |
|  |  |  |  |  |  |
|  |  | Disfigurement |  |  | Permanent Total Disability Benefits |
|  |  |  |  |  |  |
|  |  |  |  |  | Death Benefits |
|  |  |  |  |  |  |
|  |  | Penalties: Describe with specificity the grounds on which a penalty is asserted, including the order, rule or section of the statute allegedly violated, and the dates on which you claim the violation began and ended. |
|  |  |
|  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  | Other issues to be heard at this hearing are (such as maximum medical improvement, termination of benefits, etc): |  |
|  |
|  |  |  |
|  |  |  |

|  |
| --- |
| Witnesses to be called at the hearing or by deposition: List names and addresses: |
|  |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |
| 6. |  |  |
|  | (Attach additional pages if necessary) |  |
| **B.** | **Signature**: |
| **X** |  |  |  |  |
|  | Signature  |  | Attorney Registration Number  |  |
| First Name |  | MI  |  | Last Name: |  | Suffix |  |  |
| Company |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone  |  |  |
| E-mail |  |  |  |  |
|  |
| **C.** | **Certificate of Mailing** |
| I hereby certify that I mailed or delivered true and correct copies of the RESPONSE TO APPLICATION FOR HEARING to all parties at the addresses shown below: (A claimant must provide a copy to the employer and the insurer, or their attorney.): |
| Party 1 | First Name |  | MI |  | Last Name |  | Suffix |  |  |
| Company |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone  |  |  |
| E-mail |  | Recipient is the: |  |  |
|  |
| Party 2 | First Name |  | MI |  | Last Name |  | Suffix |  |  |
| Company |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone |  |  |
| E-mail |  | Recipient is the: |  |  |
|  |  |
|  |  |  |  |  |
|  | Signature of person serving the document |  | Date served | Rev 3/17 |