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| STATE OF COLORADO |  |
| OFFICE OF ADMINISTRATIVE COURTS |
|  | [ ] 1525 Sherman Street, 4th Floor, Denver, CO 80203 Fax: (303) 866-5909 |  |
|  | [ ] 1259 Lake Plaza Drive, Suite 230, Colo. Springs, CO 80906 Fax: (719) 576-2978 |  |
|  | [ ] 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Fax: (970) 248-7341 |
|  |  |
|  |  |  |
| Claimant, |
|  |
|  | 🟂 **COURT USE ONLY** 🟂 |
| vs. | **WC NUMBER:** |
|  |  |  |  |  |  |
| Employer, and |  |
|  |  |  | **DATE OF INJURY:** |
| Respondent. |  |  |  |
|  |  |
| **APPLICATION FOR EXPEDITED HEARING****ONE-TIME CHANGE OF AUTHORIZED TREATING PHYSICIAN** |
|  |  |  |  |  |
| An Expedited Hearing is requested pursuant to Rule 8-5(C), Workers’ Compensation Rules of Procedure (check all that apply):[ ] Claimant has requested a one-time change of physician (You must attach a copy of the notice.);[ ] Insurer has provided a written objection within 7 business days of the request (You must attach a copy of the written objection.);[ ] There exists a factual dispute requiring a hearing. (state below the factual dispute(s) that exist).  |
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| The opposing party may file a response to this Application for Expedited Hearing within 10 days of the mailing or delivery of this Application for Expedited Hearing. |
| 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) |  |
|  |  |
|  | The Office of Administrative Courts will set this case for hearing and will send notice to the parties.  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **X** |  |  |  |  |
|  | Signature  |  | Attorney Registration Number  |  |
| First Name |  | MI  |  | Last Name: |  | Suffix |  |  |
| Company |  |  |
| Address |  |  |
| City |  | State |  | Zip |  | Phone  |  |  |
| E-mail |  |  |
|  |
| I hereby certify that I mailed or delivered true and correct copies of the APPLICATION FOR EXPEDITED HEARINGONE-TIME CHANGE OF AUTHORIZED TREATING PHYSICIAN 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 submitting document |  | Date served | Rev 3/15 |