| STATE OF COLORADO | | | | | | | | | | | | | | | |  | | | | | | | |
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| OFFICE OF ADMINISTRATIVE COURTS | | | | | | | | | | | | | | | |
| Choose an item. | | | | | | | | | | | | | | | |
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| Claimant, | | | | | | | | | | | | | | | |
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|  | | | | | | | | | | | | | | | | 🟂 **COURT USE ONLY** 🟂 | | | | | | | |
| vs. | | | | | | | | | | | | | | | | **WC NUMBER:** | | | | | | | |
|  |  | | | | | | | | | | | | | |  |  | |  | | | | |  |
| Employer, and | | | | | | | | | | | | | | | |  | | | | | | | |
|  |  | | | | | | | | | | | | | |  | **DATE OF INJURY:** | | | | | | | |
| Respondent. | | | | | | | | | | | | | | | |  | |  | | | | |  |
|  | | | | | | | | | | | | | | | |  | | | | | | | |
| **APPLICATION FOR HEARING - DISFIGUREMENT ONLY (RULE 10, OACRP)** | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| The claimant requests a determination of additional compensation for permanent disfigurement. Section 8-42-108, C.R.S. Disfigurement will be the only issue determined at the hearing and the claimant will be the only witness, unless a response is filed adding affirmative defenses and listing additional witnesses. | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | |
| The opposing party may file a response to this Application for Hearing - Disfigurement Only within 10 days of the mailing or delivery of this Application for Expedited Hearing.  The Office of Administrative Courts will set the matter for hearing and send a written Notice of Hearing to the parties. | | | | | | | | | | | | | | | | | | | | | | | |
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| **X** | |  | | | | | | | | | |  | |  | | | | | | | |  | |
|  | | Signature | | | | | | | | | |  | | Attorney Registration Number | | | | | | | |  | |
| First Name | | | |  | MI |  | Last Name: | | |  | | | | | | | | | Suffix |  |  | | |
| Company | | | |  | | | | | | | | | | | | | | | | |  | | |
| Address | | | |  | | | | | | | | | | | | | | | | |  | | |
| City | | | |  | | | | State |  | Zip |  | | Phone | | | |  | | | |  | | |
| E-mail | | | |  | | | | | | | | | | | | | | | | |  | | |
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| I hereby certify that I mailed or delivered true and correct copies of the **APPLICATION FOR HEARING - DISFIGUREMENT ONLY (RULE 10, OACRP)** 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 document | | | | | | | | | | |  | Date served | | | | | | Rev 3/17 | |