| State of Colorado | | | | | | | | | | | | | | | 🟂 **Court Use Only** 🟂 | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Office of Administrative Courts | | | | | | | | | | | | | | |
| ☐ 1525 Sherman St., 4th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us **☐** 2864 S. Circle Dr, Ste 810, Colo. Springs, CO 80906 Email: oac-csp@state.co.us  **☐** 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Email: oac-gjt@state.co.us | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | |  | |
| Claimant, | | | | | | | | | | | | | | |
| v. | | | | | | | | | | | | | | | **WC Number:** | | | | |
|  |  | | | | | | | | | | | |  | |  |  | | |  |
|  | Employer/Respondent, and | | | | | | | | | | | |  | |  | | | | |
|  |  | | | | | | | | | | | |  | | **Date of Injury:** | | | | |
|  | Insurer/Respondent. | | | | | | | | | | | |  | |  |  | | |  |
|  | | | | | | | | | | | | | | |  | | | | |
| **Application for Hearing** | | | | | | | | | | | | | | | | | | | |
| **You must complete all sections of Application (Sections A, B, C, & D)** | | | | | | | | | | | | | | | | | | | |
| **A.** | | | **Application for Hearing** | | | | Filed by or for: | | |  | | | | | | | |  | |
|  | | |  | | | |  | | | (Print Name of Party) | | | | | | | |  | |
| It is requested that this matter be set for hearing in (check one): | | | | | | | | | | | | | | | | | | | |
| **☐** | | | Denver | | **☐** | Colorado Springs | | **☐** | Grand Junction | | **☐** | Pueblo | | **☐** | | | Glenwood Springs | | |
|  | | **☐** | | Check here to certify that you have attempted to resolve with the other parties all issues listed on the application for hearing as required by Section 8-43-211(4), C.R.S. | | | | | | | | | | | | | | | |
|  | | **☐** | | Check here if compensability is contested, or if this hearing is requested in response to a final admission of liability or to contest a conclusion in a Division-sponsored independent medical examination (DIME). | | | | | | | | | | | | | | | |

|  | **Issues identified for hearing (check all that apply):**  **☐** Compensability (whether claimant sustained a work injury) | | |
| --- | --- | --- | --- |
|  | **☐** Medical Benefits | **☐** Permanent Partial Disability Benefits | |
|  | **☐** Authorized Provider | **☐** Permanent Total Disability Benefits | |
|  | **☐** Temporary Total Disability Benefits | **☐** Petition to Reopen Claim | |
|  | **☐** Temporary Partial Disability Benefits | **☐** Disfigurement | |
|  | **☐** Average Weekly Wage | **☐** 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. (Section 8-43-304(4), C.R.S.)*(Attach additional pages as needed)* | | |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  | **☐** Other issues to be heard at this hearing are (such as maximum medical improvement, termination of benefits, etc.) *(Attach additional pages as needed)*: | | |
|  |  | | |
|  |  | | |
|  |  | | |

|  | Witnesses to be called at the hearing or by deposition (List names and addresses): | | | | |
| --- | --- | --- | --- | --- | --- |
|  | | Name |  | Address |  |
| 1. | |  |  |  |  |
| 2. | |  |  |  |  |
| 3. | |  |  |  |  |
| 4. | |  |  |  |  |
|  | | *(Attach additional pages as necessary)* | | |  |
| **B.** | | **Setting Case for Hearing** | | |  |
| **☐** | | I am not represented by an attorney and would like the Office of Administrative Courts to set a hearing for me. (Rule 8(D) OACRP). | | |  |
| **☐** | | The undersigned will contact the Office of Administrative Courts, at [www.colorado.gov/oac](http://www.colorado.gov/oac), to obtain dates for a hearing. The applicant shall confer with the opposing parties and file a written hearing confirmation form with the Office of Administrative Courts. | | |  |
| **Complete Sections C and D** | | | | | |

| **C.** | **Signature of Party or Attorney** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **X** |  | | | |  |  | |  |
|  | Signature | | | | | Attorney Registration Number (if applicable) | | |
| First Name: | | | Last Name: | | | | | |
| Company: | | | | | | | | |
| Address: | | | | | | | | |
| City: | | State: | | Zip: | | | Phone: | |
| E-mail: | | | | | | | | |

| **D:** | **Certificate of Service or Mailing** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I hereby certify that I mailed or delivered true and correct copies of the Amended 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: | | Last Name: | | | | | |
| Company: | | | | | | | |
| Address: | | | | | | | |
| City: | State: | | Zip: | | | Phone: | |
| E-mail: | | | | | | | |
| Party 2 | | First Name: | | Last Name: | | | | | |
| Company: | | | | | | | |
| Address: | | | | | | | |
| City: | State: | | Zip: | | | Phone: | |
| E-mail: | | | | | | | |
|  | |  | | | |  |  | |  |
|  | | Signature of person serving document | | | |  | Date served | | Revised 5/25 |