

State of Colorado Office of Administrative Courts	
<input type="checkbox"/> 1525 Sherman St., 4 th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us <input type="checkbox"/> 2864 S. Circle Dr, Ste 810, Colo. Springs, CO 80906 Email: oac-csp@state.co.us <input type="checkbox"/> 222 S. 6 th Street, Suite 414, Grand Jct., CO 81501 Email: oac-gjt@state.co.us	
_____ Claimant, v. _____ Employer/Respondent, and _____ Insurer/Respondent.	<div style="text-align: center;">▲ Court Use Only ▲</div> <div style="text-align: center; margin-top: 10px;"> WC Number: _____ </div> <div style="text-align: center; margin-top: 10px;"> Date of Injury: _____ </div>
Amendment to _____ Application for Hearing <i>Date of Application for Hearing</i>	
You must complete all sections of Application (Sections A, B, C, & D)	
<p>A. Application for Hearing Filed by or for: _____ <div style="text-align: right;">(Print Name of Party)</div></p> <p>It is requested that this matter be set for hearing in (check one):</p> <p> <input type="checkbox"/> Denver <input type="checkbox"/> Colorado Springs <input type="checkbox"/> Grand Junction <input type="checkbox"/> Pueblo <input type="checkbox"/> Glenwood Springs </p> <p style="margin-top: 20px;"> <input type="checkbox"/> 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. </p> <p style="margin-top: 20px;"> <input type="checkbox"/> 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). </p>	

Issues identified for hearing (select 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, 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