| State of Colorado |
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| 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 |
| Audio Recording Request |
| Today’s Date:  | W.C. Number:  |
| Case Name:  | Party Making Request: |
| Hearing Date: | Hearing Location: | Courtroom (if applicable): |
| Is this a Workers’ Compensation hearing | ☐ | Yes | ☐ | No | Video Hearing?  | ☐ Yes | ☐ No |
| Hearing Start Time:  | Hearing End Time: | Judge: |
| **Requests for written transcripts will be forwarded to an outside transcription service for preparation. If requesting a transcript, you must provide the name and address of the transcriptionist or court reporter to whom OAC will send a copy of the recording.** |
| I am requesting a copy of: | ☐ | Recording of the hearing only. (audio link to be provided). |
|  | ☐ | Written transcript of the hearing only.  |
|  | ☐ | Both the recording and written transcript of the hearing.  |
| Transcriptionist Name: |
| Transcriptionist Address: |
| By signing this request, I acknowledge that the filing of this form with the Office of Administrative Courts **does not** constitute filing an appeal of this case. I further acknowledge that if this request is in conjunction with a Worker’s Compensation Petition to Review or other form of Appeal that additional filing requirements may need to be met pursuant to any and all applicable statutes or rules of the agency/department involved. |
|  |  |
| **X** |  |  |  |  |
|  | Signature  | Attorney Registration Number (if applicable) |
| First Name:  | Last Name:  |
| Company:  |
| Address:  |
| City:  | State: | Zip:  | Phone:  |
| E-mail:  |

|  | **Certificate of Service or Mailing** |
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| I hereby certify that I mailed or delivered true and correct copies of the Audio Recording Request 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 |