

State of Colorado Office of Administrative Courts		▲ Court Use Only ▲ WC Number: Date of Injury:	
<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			
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"> Claimant, </div> <div style="margin-bottom: 5px;">v.</div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"> Employer/Respondent, and </div> <div style="border-bottom: 1px solid black;"> Insurer/Respondent. </div>			
Application for Hearing Disfigurement Only (Rule 10, OACRP)			
You must complete all sections of Application (Sections A, B, C, & D)			
A. Grounds for Hearing 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. <div style="text-align: center; padding: 10px;"> 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 </div>			
B. Setting Case for Hearing The Office of Administrative Courts will set this case for hearing and will send a written Notice of Hearing to the parties.			
C. Signature of Party or Attorney <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 45%;"> X <div style="border-bottom: 1px solid black; margin-top: 5px; width: 90%;"></div> Signature </div> <div style="width: 45%;"> <div style="border-bottom: 1px solid black; margin-top: 5px; width: 90%;"></div> Attorney Registration Number (if applicable) </div> </div>			
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:			
<div>Signature of person serving document</div> <div>Date served</div> <div>Revised 5/25</div>				