| 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. | | | | | |  | |  |  | | |  |
|  | | | | | | | | |  | | | | |
| **Entry of Appearance/Substitution of Counsel** | | | | | | | | | | | | | |
| You are hereby notified that the undersigned attorney is entering his/her appearance in the above-captioned matter before the Office of Administrative Courts, pursuant to Rule 8(C), O.A.C.R.P. I represent the following client(s): | | | | | | | | | | | | | |
|  | | ☐ Claimant | | ☐ Insurer | ☐ Employer | ☐ Dependent | | ☐ Other | | |  |  | |
|  | | Party Name: |  | | | | | | | | |  | |
|  | | If substituting as counsel, enter former counsel’s name: | | | |  | | | | | |  | |
|  | |  | | | | | | | | | |  | |

|  | **Signature of Attorney** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **X** |  | | | |  |  | |  |
|  | Signature | | | | | Attorney Registration Number | | |
| First Name: | | | Last Name: | | | | | |
| Company: | | | | | | | | |
| Address: | | | | | | | | |
| City: | | State: | | Zip: | | | Phone: | |
| E-mail: | | | | | | | | |

|  | **Certificate of Service or Mailing** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I hereby certify that I mailed or delivered true and correct copies of the Entry of Appearance/Substitution of Counsel 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 |