State of Colorado

Office of Administrative Courts

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Workers' Compensation Hearing Cancellation

Today's Date:	WC Number:	
Case Name:		
Hearing Date:	Hearing Time:	Hearing Location:
Attorney or Pro Se Party requesting cancellation:		
Email:		

☐ **Check here to certify that you have conferred with the opposing party and that they agree to cancel this hearing.**

Reason for Cancellation:

☐ Issue(s) Resolved

☐ Case Settled

☐ Application/Appeal Withdrawn

Certificate of Service or Mailing

I hereby certify that I mailed or delivered true and correct copies of the Hearing Cancellation 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:
	Email:			
Party 2	First Name:	Last Name:		
	Company:			
	Address:			
	City:	State:	Zip:	Phone:
	Email:			

Signature of person serving document

Date served

Revised 5/25