

State of Colorado**Office of Administrative Courts**

1525 Sherman St., 4th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us
 1330 Inverness Drive, Suite 330, Colo. Springs, CO 80910 Email: oac-csp@state.co.us
 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Email: oac-gjt@state.co.us

Workers' Compensation Hearing Cancellation

Today's Date:	WC Number:
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Case Name:

Hearing Date:	Hearing Time:	Hearing Location:
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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Application/Appeal Withdrawn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:
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Company:

Address:

City:	State:	Zip:	Phone:
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Email:

Party 2

First Name:	Last Name:
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Company:

Address:

City:	State:	Zip:	Phone:
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Email:

Signature of person serving document

Date served

Revised 11/25