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| --- | --- | --- | --- | --- | --- | --- |
| State of Colorado | | | | | | |
| 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 | | | | | | |
| 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|  | |  | Application/Appeal Withdrawn | | | |

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|  | **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 |