

State of Colorado**Office of Administrative Courts**

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Workers' Compensation Hearing Confirmation

Today's Date:

WC Number:

Case Name:

If this is a continuation of a previously held hearing, enter the name of the presiding ALJ:

Is this for a rescheduled hearing?

☐ Yes☐ No

Hearing Date:

Hearing Time:

Hearing Location:

Attorney or Pro Se Party confirming hearing date:

Email:

Representing:

☐ Claimant☐ Respondent (Specify which):**Certificate of Service or Mailing**

I hereby certify that I mailed or delivered true and correct copies of the Hearing Confirmation 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