

State of Colorado Office of Administrative Courts		▲ Court Use Only ▲ WC Number: Date of Injury:
<input type="checkbox"/> 1525 Sherman St., 4 th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us <input type="checkbox"/> 1330 Inverness Drive, Suite 330, Colo. Springs, CO 80910 Email: oac-csp@state.co.us <input type="checkbox"/> 222 S. 6 th Street, Suite 414, Grand Jct., CO 81501 Email: oac-gjt@state.co.us		
_____ Claimant, v. _____ Employer/Respondent, and _____ Insurer/Respondent.		
Response to Application for Hearing dated _____		
A. Response to Application for Hearing: Filed by or for: _____ (Print Name of Party)		
In addition to the issues identified on the Application for Hearing, the following issues are identified for hearing: <input type="checkbox"/> Compensability (whether claimant sustained a work injury) <input type="checkbox"/> Medical Benefits <input type="checkbox"/> Authorized provider <input type="checkbox"/> Temporary Total Disability Benefits <input type="checkbox"/> Temporary Partial Disability Benefits <input type="checkbox"/> Average Weekly Wage <input type="checkbox"/> Penalties: Describe with specificity the grounds on which a penalty is asserted, including the order, rule or section of the statute allegedly violated, and the dates on which you claim the violation began and ended. (Section 8-43-304(4), C.R.S.)(Attach additional pages as needed) _____ _____		

☐ Other issues to be heard at this hearing are (such as maximum medical improvement, termination of benefits, etc.) *(Attach additional pages as needed)*:

Witnesses to be called at the hearing or by deposition: List names and addresses: *(Attach additional pages as needed)*

1. _____
2. _____
3. _____
4. _____

B. Signature of Party or Attorney

X

Signature

Attorney Registration Number (if applicable)

First Name:

Last Name:

Company:

Address:

City:

State:

Zip:

Phone:

Email:

C: Certificate of Service or Mailing

I hereby certify that I mailed or delivered true and correct copies of the Response to Application for Hearing 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