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| State of Colorado | 🟂 **Court Use Only** 🟂 |
| 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 |
|  |  |  |
| Claimant, |
| v. | **WC Number:** |
|  |  |  |  |  |  |
|  | Employer/Respondent, and |  |  |
|  |  |  | **Date of Injury:** |
|  | 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:** [ ]  Compensability (whether claimant sustained a work injury) |
|  | [ ]  Medical Benefits | [ ]  Permanent Partial Disability Benefits |
|  | [ ]  Authorized provider | [ ]  Permanent Total Disability Benefits |
|  | [ ]  Temporary Total Disability Benefits  | [ ]  Petition to Reopen Claim |
|  | [ ]  Temporary Partial Disability Benefits | [ ]  Disfigurement |
|  | [ ]  Average Weekly Wage | [ ]  Death Benefits |
|  | [ ]  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)* |
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|  | [ ]  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 |