|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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)* | | | | | | | | | | |
|  |  | |  | | | | | | | |  |
|  |  | |  | | | | | | | |  |
|  |  | |  | | | | | | | |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 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 | |