

**STATE OF COLORADO
OFFICE OF ADMINISTRATIVE COURTS**

- 1525 Sherman Street, 4th Floor, Denver, CO 80203 Email: oac-dvr@state.co.us
- 2864 S. Circle Dr., Suite 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,

vs.

Employer, and

Respondent.

▲ **COURT USE ONLY** ▲

WC NUMBER:

DATE OF INJURY:

APPLICATION FOR HEARING

A. Application for Hearing: Filed by or for: _____
(Print Name of Party)

It is requested that this matter be set for hearing in (check one):

- Denver Colorado Spgs Grand Jct. Pueblo Glenwood Spgs

Check here to certify that you have attempted to resolve with the other parties all issues listed on the application for hearing (Section 8-43-211(4), C.R.S.). If compensability is contested, or if this hearing is requested in response to a final admission of liability or to contest a conclusion in a Division sponsored independent medical examination, checking this box is not required.

The following issues shall be considered at the hearing:

- | | |
|---|--|
| <input type="checkbox"/> Compensability | <input type="checkbox"/> Temporary Total Benefits from _____ to _____ <input type="checkbox"/> Ongoing |
| <input type="checkbox"/> Medical Benefits | <input type="checkbox"/> Temporary Partial Benefits from _____ to _____ <input type="checkbox"/> Ongoing |
| <input type="checkbox"/> Authorized provider | <input type="checkbox"/> Permanent Partial Disability Benefits |
| <input type="checkbox"/> Average Weekly Wage | <input type="checkbox"/> Permanent Total Disability Benefits |
| <input type="checkbox"/> Petition to Reopen Claim | <input type="checkbox"/> Death Benefits |
| <input type="checkbox"/> Disfigurement | |

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.
(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:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(Attach additional pages as necessary)

B. Request for the OAC to Set the Matter for Hearing Rule 8(E) OACRP:

If you are not represented by an attorney and would like the Office of Administrative Courts to set this case for you, please check here: Complete Sections C and D.

The undersigned will contact the Office of Administrative Courts, at www.colorado.gov/oac, to obtain dates for hearing. The applicant shall confer with the opposing parties and file a written confirmation with the OAC.

C. Signature:

X _____
Signature Attorney Registration Number

First Name _____ MI ____ Last Name _____ Suffix _____
Company _____
Address _____
City _____ State ____ Zip _____ Phone _____
E-mail _____

D: Certificate of Mailing

I hereby certify that I mailed or delivered true and correct copies of the 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.):

| | |
|--|---|
| | First Name _____ MI ____ Last Name _____ Suffix _____ |
| | Company _____ |
| | Address _____ |
| | City _____ State ____ Zip _____ Phone _____ |
| | E-mail _____ Recipient is the: _____ |

| | |
|--|---|
| | First Name _____ MI ____ Last Name _____ Suffix _____ |
| | Company _____ |
| | Address _____ |
| | City _____ State ____ Zip _____ Phone _____ |
| | E-mail _____ Recipient is the: _____ |

Signature of person serving document

Date served