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| STATE OF COLORADO | | | | | | | | |  | | | | | |
| OFFICE OF ADMINISTRATIVE COURTS | | | | | | | | |
|  | | 1525 Sherman Street, 4th Floor, Denver, CO 80203 Fax: (303) 866-5909 | | | | | |  | | | | | |
|  | | 1259 Lake Plaza Drive, Suite 230, Colo. Springs, CO 80906 Fax: (719) 576-2978 | | | | | |  | | | | | |
|  | | 222 S. 6th Street, Suite 414, Grand Jct., CO 81501 Fax: (970) 248-7341 | | | | | |
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| Claimant, | | | | | | | | |
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|  | | | | | | | | | 🟂 **COURT USE ONLY** 🟂 | | | | | |
| vs. | | | | | | | | | **WC NUMBER:** | | | | | |
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| Employer, and | | | | | | | | |  | | | | | |
|  |  | | | | | |  | | **DATE OF INJURY:** | | | | | |
| Respondent. | | | | | | | | |  |  | | |  | |
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| **APPLICATION FOR EXPEDITED HEARING**  **ONE-TIME CHANGE OF AUTHORIZED TREATING PHYSICIAN** | | | | | | | | | | | | | | |
|  | | | |  |  |  | | | | |  | | | |
| An Expedited Hearing is requested pursuant to Rule 8-5(C), Workers’ Compensation Rules of Procedure (check all that apply):  Claimant has requested a one-time change of physician (You must attach a copy of the notice.);  Insurer has provided a written objection within 7 business days of the request (You must attach a copy of the written objection.);  There exists a factual dispute requiring a hearing. (state below the factual dispute(s) that exist). | | | | | | | | | | | | | | |
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| The opposing party may file a response to this Application for Expedited Hearing within 10 days of the mailing or delivery of this Application for Expedited Hearing. | | | | | | | | | | | | | | |
| Witnesses to be called at the hearing or by deposition: List names and addresses: | | | | | | | | | | | | | | |
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| 1. | | |  | | | | | | | | |  | | |
| 2. | | |  | | | | | | | | |  | | |
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| 6. | | |  | | | | | | | | |  | | |
|  | | | (Attach additional pages if necessary) | | | | | | | | |  | | |
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|  | | | The Office of Administrative Courts will set this case for hearing and will send notice to the parties. | | | | | | | | | | | |
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| **X** | |  | | | | | | | | | | | | | | | | | | | | |  | |  | | | | | | | | | | | | |  |
|  | | Signature | | | | | | | | | | | | | | | | | | | | |  | | Attorney Registration Number | | | | | | | | | | | | |  |
| First Name | | | |  | | MI | |  | | | Last Name: | | | | | | | |  | | | | | | | | | | | | | Suffix | |  | | |  | |
| Company | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| City | | | |  | | | | | | | | State | |  | | | | Zip | | | |  | | Phone | | | |  | | | | | | | | |  | |
| E-mail | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| I hereby certify that I mailed or delivered true and correct copies of the APPLICATION FOR EXPEDITED HEARING  ONE-TIME CHANGE OF AUTHORIZED TREATING PHYSICIAN 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 | |  | | MI | | |  | | Last Name | | | |  | | | | | | | | | | | | | | | Suffix | |  | | |  | | |
| Company | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| City | |  | | | | State | | | |  | | | | Zip | | |  | | | | | | | | | Phone |  | | | | | |  | | |
| E-mail | |  | | | | | | | | | | Recipient is the: | | | | | | | | | | | |  | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Party 2 | | First Name | |  | | MI | |  | | | Last Name | | | |  | | | | | | | | | | | | | | | Suffix | |  | | |  | | |
| Company | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| Address | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| City | |  | | | | State | | | |  | | | | Zip | | |  | | | | | | | | | Phone |  | | | | | |  | | |
| E-mail | |  | | | | | | | | | | Recipient is the: | | | | | | | | | | | |  | | | | | | | | |  | | |
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|  | | Signature of person submitting document | | | | | | | | | | | | | | | | | |  | | | | | Date served | | | | | | | | | Rev 3/15 | | | |