

**COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION**

**LEVEL II REACCREDITATION
REPORT SUBMISSION FORM
Per Workers' Compensation Rule 13-3**

Date Submitted _____

Physician Name _____

Business Address _____

Phone _____

Fax _____

Email _____

Board License Number _____

Number of Reports Enclosed/Attached _____

SUBMIT REPORTS ATTN: KARI GOMES, PT, DPT

VIA FAX: 303-318-8659

OR

**VIA MAIL: Division of Workers' Compensation
Physicians' Accreditation
Attn: Kari Gomes, PT, DPT
633 - 17th Street, Suite 400
Denver, CO 80202-3660**