

**STATE OF COLORADO  
OFFICE OF ADMINISTRATIVE COURTS**

1525 Sherman Street, 4<sup>th</sup> Floor, Denver, CO 80203 Fax: (303) 866-5909  
1259 Lake Plaza Drive, Suite 230, Colo. Springs, CO 80906 Fax: (719) 576-2978  
222 S. 6<sup>th</sup> Street, Suite 414, Grand Jct., CO 81501 Fax: (970) 248-7341

\_\_\_\_\_  
Claimant,

vs.

\_\_\_\_\_  
Employer, and

\_\_\_\_\_  
Respondent.

▲ COURT USE ONLY ▲

WC NUMBER:  
\_\_\_\_\_

DATE OF INJURY:  
\_\_\_\_\_

**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 (attach a copy of the notice);

Insurer has provided a written objection within 7 business days of the request (attach a copy of the written objection);

There exists a factual dispute requiring a hearing. (state below the factual dispute(s) that exist).

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:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

(Attach additional pages if necessary)

The Office of Administrative Courts to set this case for hearing and will send notice to the parties.

X \_\_\_\_\_  
Signature  
First Name \_\_\_\_\_ Last Name: \_\_\_\_\_ Attorney Registration Number \_\_\_\_\_  
Company \_\_\_\_\_ Middle Initial \_\_\_\_\_ Suffix \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

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.):

Claimant/Responent or their Representative:	First Name _____ Last Name: _____ Middle Initial _____ Suffix _____ Company _____ Address _____ City _____ State ____ Zip ____ Phone _____ E-mail _____
Employer or their Representative:	First Name _____ Last Name: _____ Middle Initial _____ Suffix _____ Company _____ Address _____ City _____ State ____ Zip ____ Phone _____ E-mail _____
Other:	First Name _____ Last Name: _____ Middle Initial _____ Suffix _____ Company _____ Address _____ City _____ State ____ Zip ____ Phone _____ E-mail _____
Signature _____ Date Mailed _____	

REV 11/13