

**STATE OF COLORADO  
OFFICE OF ADMINISTRATIVE COURTS**

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

vs.

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

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

▲ **COURT USE ONLY** ▲

**WC NUMBER:**

**DATE OF INJURY:**

**APPLICATION FOR HEARING - DISFIGUREMENT ONLY (RULE 10, OACRP)**

The claimant requests a determination of additional compensation for permanent disfigurement. Section 8-42-108, C.R.S. Disfigurement will be the only issue determined at the hearing and the claimant will be the only witness, unless a response is filed adding affirmative defenses and listing additional witnesses.

The opposing party may file a response to this Application for Hearing - Disfigurement Only within 10 days of the mailing or delivery of this Application for Expedited Hearing.

The Office of Administrative Courts will set the matter for hearing and send a written Notice of Hearing to the parties.

**X** \_\_\_\_\_  
Signature Attorney Registration Number

First Name \_\_\_\_\_ MI \_\_\_\_ Last Name: \_\_\_\_\_ Suffix \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_ Phone \_\_\_\_\_

E-mail \_\_\_\_\_

I hereby certify that I mailed or delivered true and correct copies of the **APPLICATION FOR HEARING - DISFIGUREMENT ONLY (RULE 10, OACRP)** 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: \_\_\_\_\_

\_\_\_\_\_  
Signature of person submitting document

\_\_\_\_\_  
Date served

**Rev 3/15**