

Division of Workers' Compensation  
Physicians' Accreditation  
633 17th St., Suite 400  
Denver, Colorado 80202-3626  
303.318.8763

## PROVIDER COMPLIANCE AGREEMENT

### Provider's Information (Please print):

Name of Provider: \_\_\_\_\_

Address of Provider: \_\_\_\_\_

Street Address

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip

### Certification Section:

I certify that I will adhere to:

- a. The Medical Treatment Guidelines as adopted by the Director of the Division of Workers' Compensation.
- b. The utilization standards and rules as adopted by the Director of the Division of Workers' Compensation.
- c. All of the Colorado Workers' Compensation laws and rules as they apply to me as a health care provider in the Colorado Workers' Compensation system.

Failure to abide by the Medical Treatment Guidelines, utilization standards, and rules and regulations established by the Director of the Division of Workers' Compensation could result in revocation of my accreditation, pursuant to C.R.S. Section 8-42-101 (3.6).

I understand and agree to comply with the terms listed above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to the Division of Workers' Compensation, Physicians' Accreditation. The address is listed at the top of this form.

For Division of Workers' Compensation use only:

Date received: \_\_\_\_\_ Received by: \_\_\_\_\_

DOWC authorized signature