Go to Form

Instructions for Completing the

Designated Health Care Provider Disclosure Form

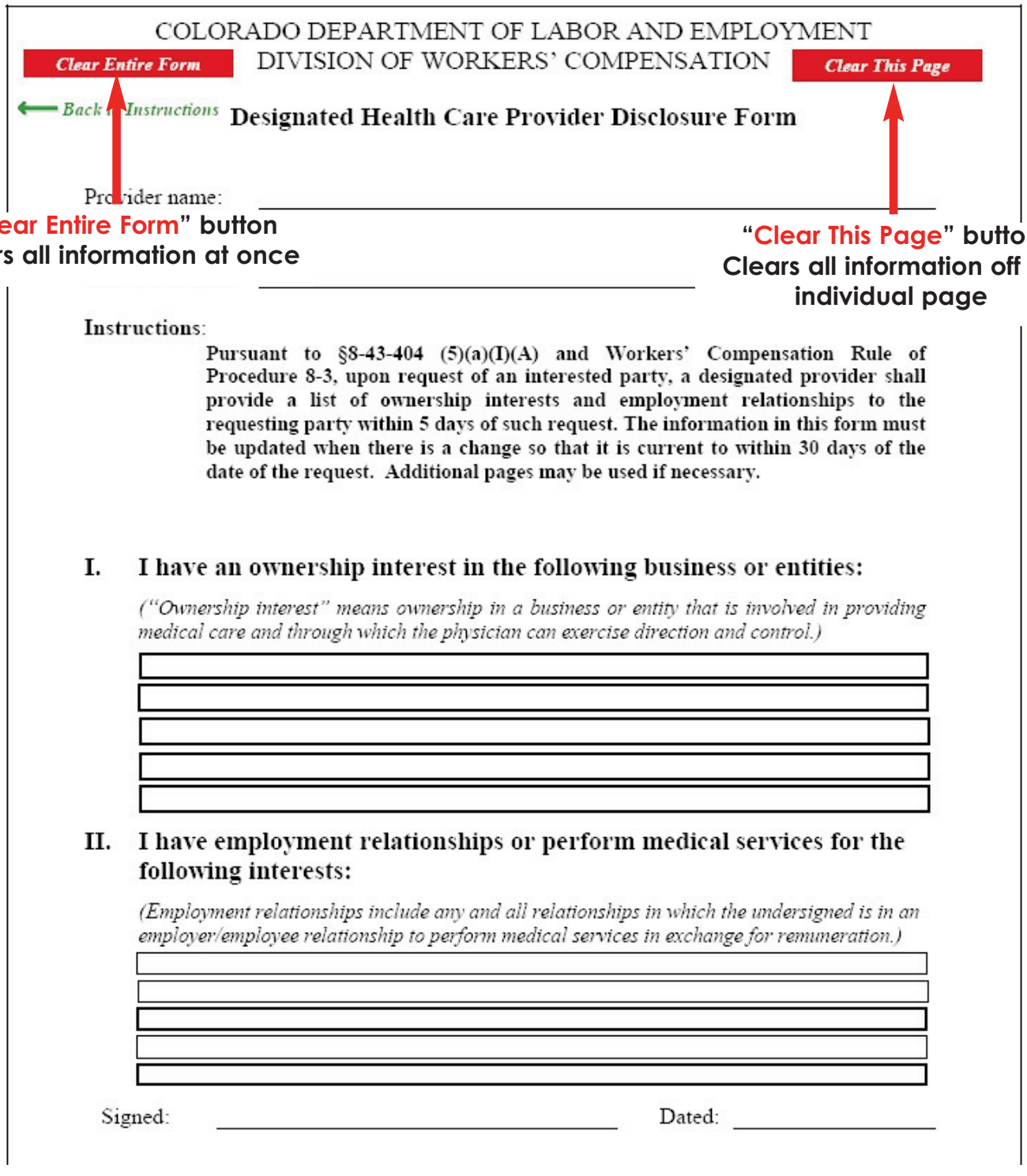
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Claimant" box (field), complete the information, and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for phone number and dollar amounts. Do not use dashes, parentheses or dollar signs; when you tab out of the field, it will fill in automatically. If a dollar amount contains cents, *do* type the period. To fill in a check box, click inside the box with your mouse.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. To clear all information on a single page, click on the red "Clear This Page" button. To change the information in one field, use the backspace or delete key.



"Clear Entire Form" button
Clears all information at once

"Clear This Page" button
Clears all information off an individual page

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT

Clear Entire Form

DIVISION OF WORKERS' COMPENSATION

Clear This Page

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Designated Health Care Provider Disclosure Form

Provider name: _____

Provider address: _____

Instructions:

Pursuant to §8-43-404 (5)(a)(I)(A) and Workers' Compensation Rule of Procedure 8-3, upon request of an interested party, a designated provider shall provide a list of ownership interests and employment relationships to the requesting party within 5 days of such request. The information in this form must be updated when there is a change so that it is current to within 30 days of the date of the request. Additional pages may be used if necessary.

I. I have an ownership interest in the following business or entities:

("Ownership interest" means ownership in a business or entity that is involved in providing medical care and through which the physician can exercise direction and control.)

II. I have employment relationships or perform medical services for the following interests:

(Employment relationships include any and all relationships in which the undersigned is in an employer/employee relationship to perform medical services in exchange for remuneration.)

Signed: _____ Dated: _____

CERTIFICATE OF MAILING: Copies of this document were placed in the U.S. mail or delivered to the following parties this _____ day of _____ , _____ .
Day Month Year

Clear This Page

List the names and addresses of all persons copied:

By: _____
Signature