Colorado Division of Workers' Compensation
Provider Education
633 17th St., Suite 400
Denver, Colorado 80202-3626
303.318.8754

PROVIDER COMPLIANCE AGREEMENT

Provider's Information (Please print):

First and Last Name: ______________________________

Preferred Email Address: ______________________________

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 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). You must remain licensed by your Colorado Medical Board Specialty to maintain your accreditation.

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

Signature: ______________________ Date: ____________

Please return this form to the Division of Workers' Compensation, Provider Education Unit by email: cdle_dowc_provider_education@state.co.us or fax: (303)318-8659.