Clear This Form

DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th Street, 4th Floor
Denver, CO 80202-3626
(303) 318-8700

REQUEST FOR SERVICES

Date: _____ SSN: _____

Claimant Name: _____

Service Requested:

☐ Examine Records ☐ Copy Complete File

☐ Copy Paper Clipped Pages Only ☐ Certified Copy

☐ Other: _____

Authority to this information:

☐ Enclosed Entry

☐ Enclosed Release

☐ A Party to W.C. #: _____

☐ a. Employer ☐ b. Insurance Carrier ☐ c. Claimant

☐ Attorney for Claimant or Respondent

Name of Requesting Attorney:

_____

W.C. #	DOWC Use Only	
	LOC	PGS

Note: Dates of injury after July 1, 1989 require a Division notarized authorization signed by the claimant, for all non-party requestors.

Billing Information

Job #: _____ Invoice #: _____ **DOWC Use Only**

Contact: _____ Phone #: ( ) _____ Ext. _____

Agency: _____ Fax #: ( ) _____

Address: _____ JOB: ☐ Mail ☐ Pickup ☐ Rush

_____ Received By: _____

_____ Date: _____

DOWC Use Only

Quantity	Item	Unit Cost	Total Cost			By	Date
	Copy	$0.25			Approved		
	Rush	$0.50			Copied		
	Certified Copy	$2.00			Contacted		
	Fax	$1.00			Posted		
	Postage						
		TOTAL					

SUBMIT COMPLETED FORM TO: cdle_dowc_rfs@state.co.us DO NOT PRINT/MAIL