Clear Entire Form

STATE OF COLORADO
Division of Workers' Compensation

WC Number: _____

IN THE MATTER OF THE CLAIM OF

_____
Claimant

v.

_____
Employer,

and

_____
Insurer,
Respondents.

REQUEST FOR DISFIGUREMENT AWARD (PHOTO)

I was injured as the result of an industrial injury or occupational disease that occurred on

_____ , _____ , _____ .
month day year

I have a serious permanent disfigurement to an area of my body normally exposed to public view. The disfigurement is to my _____ .
list part or parts of body that are normally exposed to public view

The injury occurred at least six months ago, or my authorized treating physician has placed me at maximum medical improvement. **I have attached photographs that clearly show the disfigurement, a photograph of my face for identification purposes and have dated and signed the back of each photograph.**

Signed: _____ Dated: _____
Signature of Claimant

Print Name: _____ Phone: _____

Address: _____

A copy of this completed form and a copy of the photographs must be delivered or mailed to the Respondent-Insurer. The original form with photographs and any other attachments should be delivered or mailed to the Division of Workers' Compensation.

CERTIFICATE OF MAILING OR DELIVERY:

Copies of this document, **Request for Disfigurement Award**, were placed in the U.S. mail or delivered to the following parties this _____ day of _____ , _____ .
day month year

List names and addresses of all parties copied:

Employer: _____

_____

Carrier: _____

_____

Carrier's Attorney: _____

_____

Division of Workers' Compensation, 633 17th Street, Suite 400, Denver, CO 80202

By: _____
Signature