**Workers' Compensation Fraud Intake Form**

**COMPLAINANT'S STATEMENT WITH DETAILS OF ALLEGED OFFENSE:**

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

**LIST OF WITNESSES WHO CAN VERIFY DATES/DETAILS OF THE INCIDENT:**

<table>
<thead>
<tr>
<th>NAME:</th>
<th>ADDRESS:</th>
<th>CITY, STATE, ZIP:</th>
<th>PHONE:</th>
<th>BE SPECIFIC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>WITNESS #1:</td>
<td></td>
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<tr>
<td>WITNESS #2:</td>
<td></td>
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</tr>
</tbody>
</table>

**COMPLAINANT'S INFORMATION:**

COMPLAINANT'S NAME: ___________________________ REMAIN ANONYMOUS: Yes:_____ No:______
ADDRESS: ______________________________________
HOME PHONE: ____________________________ CELL PHONE: ____________________________
EMAIL: ______________________________________
RELATIONSHIP TO THE PERSON/BUSINESS THEY ARE REPORTING: ____________________________

Please mail the completed form to the following address:
Workers' Compensation Fraud Investigation Unit
633 17th Street, Suite 900, Denver CO 80202-3660