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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
1515 Arapahoe Street, Claims Section
Denver, CO 80202-2117

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ENTRY OF APPEARANCE

Claimant _____ Workers' Compensation Number _____

Employer _____ imber _____

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Clears all information at once**

**“Check Box”
Click in box**

_____ Workers' Compensation Number _____

You are hereby notified that the undersigned attorney is entering his/her appearance in the above-captioned matter. I am representing the following client.

(1) Claimant

(2) Carrier (Name of party)

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start 11:35 AM Thursday 5/22/2003

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th St., Suite 400
Denver, CO 80202-3660

ENTRY OF APPEARANCE

_____ Claimant	_____ Workers' Compensation Number
_____ Employer	_____ Date of Injury
_____ Insurer	_____ Claimant Social Security Number

You are hereby notified that the undersigned attorney is entering his/her appearance in the above-captioned matter. I am representing the following client.

- _____
(1) Claimant
- _____
(2) Carrier _____ (Name of party)
- _____
(3) Dependent _____ (Name of party)
- _____
(4) Employer _____ (Name of party)
- _____
(5) Other _____ (Name of party)

Attorney (print name)

Attorney Registration Number _____
Office Code

Address

City State Zip Code

Phone

Attorney Signature