Date: _____

Worker's Compensation Fraud Intake Form

COMPLAINT IS AGAINST	COMPLAINT INVOLVES
ALLEGED SUSPECT	**ALLEGED VICTIM**
NAME: _____	EMPLOYER NAME:
DOB: _____	_____
SS#: _____	ADDRESS:
ADDRESS:	_____
_____	_____
_____	PHONE: _____
HOME PHONE: _____	CARRIER: _____
CELL PHONE: _____	CARRIER CLAIM#: _____
EMAIL: _____	WC #: _____
	DOI: _____

COMPLAINANT'S STATEMENT WITH DETAILS OF ALLEGED OFFENSE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

NAME: **ADDRESS:** **CITY, STATE, ZIP:** **PHONE:** **BE SPECIFIC:**

WITNESS #1:

_____

WITNESS #2:

_____

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