

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
Division of Workers' Compensation
633 17th Street, Suite 400
Denver, Colorado 80202-2117

**AUDIT REGISTRATION FORM
LEVEL I PHYSICIAN ACCREDITATION**

The fee to audit this course is \$90.00.

Please type or print clearly

NAME: _____

BUSINESS ADDRESS: _____

CITY & ZIP: _____ BUSINESS PHONE NO.: _____

DISCIPLINE OF CARE: (Please be very specific in listing the type of medical work you do, such as NP, PA, PsyD etc.)

Specialty _____

PROFESSIONAL LICENSE NO.: _____ EXPIRATION DATE: _____
(if applicable depending on certification or specialty)

_____ I will complete the home study process.

_____ Please advise me of your next seminar.

AMOUNT ENCLOSED: \$ _____

Checks should be payable to the **Division of Workers' Compensation**. Please send the Registration Form and the Registration Fee to:

Department of Labor and Employment
DOWC/Physicians Accreditation
Post Office Box 628
Denver, Colorado 80201-0628

If you have any questions, please call the Accreditation Program Office at (303) 318-8763.

Office Information Only

Amt. Received: _____ Date Received: _____ Log # _____