CC-FORM-2

Applicable to Injuries /Deaths Occurring On or After 2/1/14

Send original to Workers' Compensation Commission and 1 copy to Insurance Carrier

Please type or print. Enter all dates in MM/DD/YY format.

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

EMPLOYER'S FIRST NOTICE OF INJURY

Full Name of Employee - LAST, FIRST, MIDDLE			Employee Email Address
Complete Address	City	State	Zip
Telephone Number	Employee's Social Security Number (LAST 5 DIGITS ONLY) XXX-X_____		
Date of Birth	Sex	Length of Employment: Years _____ Months _____ Date of Hire:_____	
Average Weekly Wage	Occupation (job description)	Was employment agreement made in Oklahoma? YES ☐ NO ☐	

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.

Date of accident or last exposure	Time of accident or exposure o'clock AM ☐ PM ☐	Date Employer Notified	Time workday began o'clock AM ☐ PM ☐
Last date employee worked	Has employee returned to work? YES ☐ NO ☐ If yes, on what date ?_____	Did the employee die? YES ☐ NO ☐ If yes, on what date ?_____	
OSHA Log Case #	Place of Accident or Occurrence City:	County:	State:

Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational Disease ☐

Nature of Injury or Illness	Does employee participate in a certified workplace medical plan: YES ☐ NO ☐ If yes, name of CWMP:

Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.

Identify part(s) of body involved in injury or illness

Full Name and address of Treating Physician (please be complete)

Employer's Insurance Carrier or Own Risk Group — Policy/Self-Insured Number _____

Name — Phone — Policy Period: From _____ To _____

Address — City — State — Zip

Employer's Name and Complete Address

Name — Federal ID# — Phone #

Address — City — State — Zip

Type of business (Example: manufacturing, food service, construction)	NAICS Number

Type of Ownership: Private ☐ State Government ☐ County Government ☐ Local Government ☐

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

The undersigned hereby declares under PENALTY OF PERJURY that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this CC-Form 2 was sent to the Workers' Compensation Commission and a copy thereof to the employer's insurer on the date noted below:

Signed _____
Signature of Preparer

By _____
Name and Title of Preparer (Please Print)

Telephone Number_____
Area Code and Number

Date_____

A CC-Form 2 must be sent to the Workers' Compensation Commission and to the employer's workers' compensation insurance carrier within 10 days after the date of receipt of notice or knowledge of death or injury that results in the loss of time beyond the shift or requires medical attention away from the work site.

PROVIDING THIS FORM TO THE COMMISSION IS NOT EVIDENCE OF ANY FACT STATED IN THE REPORT IN ANY PROCEEDING WITH RESPECT TO THE INJURY OR DEATH ON ACCOUNT OF WHICH THE REPORT IS MADE.

CC-FORM-3

USE FOR ACCIDENTAL INJURY OR CUMULATIVE TRAUMA OCCURRING ON OR AFTER FEBRUARY 1, 2014

Send original and 4 copies to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Full Name of Claimant (Injured Employee)
Name of Employer
Commission Use Only

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-3. **(Circle the change, in blue or black ink, and identify whether it adds to or replaces the prior Information.)**

EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

NOTE: Mediation is available to help resolve certain workers' compensation disputes.
For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.

(Please type or print)

COMMISSION FILE NO.

FULL NAME OF EMPLOYEE (Last, First, Middle):	Social Security Number (LAST 5 DIGITS ONLY): XXX-X	Phone: ( )
Mailing Address (include City, State & Zip):	Date of Birth: Age:	Sex:
Occupation:	Was your employment agreement in Oklahoma? YES ☐ NO ☐	Avg. Weekly Wage:
Length of Employment: Years_____ Months_____ Date of Hire:		
Date of Accident/Injury	Injury resulted from: Single Incident ☐ Cumulative Trauma ☐	Time Injury Occurred _____ ☐ AM ☐ PM
Describe parts of the body injured or affected	Place of Injury: City/County/State	
What is the nature of the Injury or Illness:	Describe with details how the injury occurred. Include object or substance which directly injured you:	

Have you filed a claim for Social Security Disability Insurance Benefits? YES ☐ NO ☐

Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of Claim for Compensation? YES ☐ NO ☐

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? _____ . If so, you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund (MITF). A claim against the MITF is commenced by filing a "CC-Form-3F" with the Workers' Compensation Commission.

Treating Physician (full name):	Address:	City:	State:	Zip:
Employer:	Employer's FEI # (Federal ID Number):	Telephone:		
Complete Mailing Address:	City:	State:	Zip:	
Complete Street Address (if different from above):	City:	State:	Zip:	

Administrative Workers' Compensation Act, 85A O.S. § 6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

CLAIM INFORMATION (Please Print)

Is this a claim for **initial** benefits (i.e. no benefits, either medical or indemnity, have been received)? ☐ YES ☐ NO

Is this a claim for **additional** benefits (e.g. additional temporary total disability, additional medical)? ☐ YES ☐ NO

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:_____

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA#
Mailing Address:	
City	State Zip
Telephone #: ( )	

NOTICE: Pursuant to 85A O.S. § 118, a fee of One Hundred Forty Dollars ($140.00) shall be collected by the Workers' Compensation Commission and assessed as costs to be paid by the party against whom any award becomes final.

The undersigned declare under PENALTY OF PERJURY that they have examined this *Employee's First Notice of Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this _____ day of _____ , _____.

_____
Signature of Claimant (must be signed by Claimant)

_____
Signature of Attorney for Claimant (if any)

Revised 4-1-21

CC-FORM-3A

USE FOR DEATHS OCCURRING ON OR AFTER FEBRUARY 1, 2014

Send original and 4 copies to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-3A. **(Circle the change, in blue or black ink, and identify whether it adds to or replaces the prior information.)**

IN THE MATTER OF THE DEATH OF (deceased employee)
Name of Claimant (individual filing claim)
Name of Employer
Commission Use Only

CLAIMANT'S FIRST NOTICE OF DEATH AND CLAIM FOR COMPENSATION

COMMISSION FILE NO.

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or in-state toll free (855) 291-3612.

(Please type or print)

FULL NAME OF DECEASED EMPLOYEE (Last, First, Middle):	Social Security Number (LAST 5 DIGITS ONLY) XXX-X_____	Phone: ( )
Mailing Address (include City, State & Zip):	Date of Birth: Age: Sex:	
Occupation:	Was deceased employment agreement made in Oklahoma? YES ☐ NO ☐	Average Weekly Wage:
Claimant's Name (Last, First, Middle):		Phone: ( )
Mailing Address (include City, State & Zip):		Relationship to Deceased
Date of Accidental Injury	Time: _____ AM ☐ PM ☐	Place of Injury: City/County/State
Date of Death	Time: _____ AM ☐ PM ☐	Place of Death: City/County/State
Nature of Injury		Body part(s) injured
Describe activities when injury occurred, with details of how event occurred. Include object or substance which directly injured deceased.		
Cause of death (normally shown on Death Certificate)		Has deceased filed a claim for compensation regarding this accident? YES ☐ NO ☐
Employer:	Federal ID#	Telephone:
Complete Mailing &/or Street Address:	City: State:	Zip:

Has a personal representative been appointed for the estate of the deceased? YES ☐ NO ☐ If yes, state name and address of the personal representative below:

List, on the reverse side of this form, the names, relationships, addresses and dates of birth of all persons who were actually dependent upon the deceased at the time of death.

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:_____

Administrative Workers' Compensation Act, 85A O.S. § 6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Name of Claimant's Attorney, if represented:

Type or Print Name of Attorney:		OBA #
Mailing Address:		
City	State	Zip
Telephone #: ( )		

The undersigned declare under PENALTY OF PERJURY that they have examined this *Notice of Death and Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this _____ day of_____, _____.

_____
Signature of Claimant (Must be signed by Claimant)

_____
Signature of Attorney for Claimant (if any)

Revised 4-1-21

CC-FORM-3B

USE FOR OCCUPATIONAL DISEASE/ILLNESS OCCURRING ON OR AFTER FEBRUARY 1, 2014

Send original and 4 copies to:
Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-3B. **(Circle the change, in blue or black ink, and identify whether it adds to or replaces the prior information.)**

Full Name of Claimant (Injured Employee)
Name of Employer
Commission use only

EMPLOYEE'S FIRST NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

COMMISSION FILE NO.

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or in-state toll free (855) 291-3612.

(Please type or print)

FULL NAME OF EMPLOYEE (Last, First, Middle):	Social Security Number (LAST 5 DIGITS ONLY): XXX-X	Phone: ( )
Mailing Address (include City, State & Zip):	Date of Birth: Age:	Sex:
Occupation:	Was your employment agreement in Oklahoma? YES ☐ NO ☐	Avg. Weekly Wage:
Length of Employment: Years _____Months_____ Date of hire: _____		

Date of last exposure to hazard which caused disease:	Date of first distinct manifestation:	Place of Injury: City/County/State
Nature of Disease (example: Reduced breathing capacity or loss of vision)		Body Part(s) Injured:
Describe how you were exposed to the disease with details of how event occurred. Include object or substance which directly injured you:		

Have you filed a claim for Social Security Disability Insurance Benefits? YES ☐ NO ☐	Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of Occupational Disease and Claim for Compensation? YES ☐ NO ☐

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? _____ If "YES", you may be entitled to benefits for combined disabilities from the Multiple Injury Trust Fund. A claim for benefits for combined disabilities against the Multiple Injury Trust Fund may be commenced by filing a "CC-Form-3F" with the Workers' Compensation Commission.

Employer:	Employer's FEI # (Federal ID Number):	Telephone:
Complete Mailing Address:	City:	State: Zip:
Complete Street Address (if different from above):	City:	State: Zip:

Administrative Workers' Compensation Act, 85A O.S. § 6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment … shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

CLAIM INFORMATION (Please Print)

Is this a claim for **initial** benefits (i.e. no benefits, either medical or indemnity, have been received)? ☐ YES ☐ NO

Is this a claim for **additional** benefits (e.g. additional temporary total disability, additional medical)? ☐ YES ☐ NO

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:_____

Name of Claimant's Attorney, if represented:

Type or Print Name of Attorney:	OBA#
Mailing Address:	
City	State Zip
Telephone #: ( )	

The undersigned declare under PENALTY OF PERJURY that they have examined this *Notice of Occupational Disease and Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this _____ day of _____ , _____

_____
Signature of Claimant (Must be signed by Claimant)

_____
Signature of Attorney for Claimant (if any)

Revised 4-1-21

CC-FORM-5

SEND COPIES TO:
1- Employee/Claimant
1 - All Other Parties of Record

In re claim of:

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

PHYSICIAN'S REPORT ON RELEASE AND RESTRICTIONS

Full Name of Employee (Claimant)
Employee's Social Security Number (LAST 5 DIGITS ONLY) XXX-X_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

COMMISSION FILE NO.	
Date of Injury	Diagnosis
Part of Body	Date of Exam

I. RELEASED FOR WORK?

☐ YES, released to: ☐ Regular Work (date): ☐ Modified Work (date): Give Restrictions (complete Section II)

☐ NO, claimant remains temporarily totally disabled.

II. RESTRICTIONS (check all that apply and describe fully under number 8 below)

☐ **No Restrictions** ☐ **Permanent Restrictions** ☐ **Temporary Restrictions**

1. ___Restricted lifting (maximum weight in pounds) 10___ 25___ 50___ Other____ Frequency _____
2. ___Restricted pushing/pulling of _____ lbs.
3. ___Restricted reaching: ☐ above chest ☐ overhead ☐ away from body
4. ___Restricted to one-handed duty. No use of: ☐ Right hand ☐ Left hand
5. ___Restricted ☐ walking ☐ standing ☐ sitting (describe fully) ☐ partial weight bearing (describe fully) ☐ bending ☐ twisting
6. ✓ Wear splint at: ☐ All Times ☐ Work ☐ Night (describe fully)
7. ___DO NOT: ☐ Operate Machinery ☐ Crawl ☐ Kneel ☐ Squat ☐ Drive any Vehicle ☐ Climb ☐ Bend ☐ Stoop ☐ Twist
8. FULLY DESCRIBE RESTRICTIONS (i.e. duration, nature of limitation, etc.) Supplement with extra pages if needed:

_____
_____
_____
_____
_____
_____
_____

III. MEDICAL & REHABILITATION

A. Is continuing medical maintenance needed? NO ☐ YES ☐ If YES, describe fully, including date of next appointment. Supplement with extra pages if needed.

B. Is vocational rehabilitation indicated? (i.e. As a result of the injury, is the employee unable to perform work for which the person has previous training or experience?) NO ☐ YES ☐

I declare under PENALTY OF PERJURY that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Employee/Counsel		
Address (Number & Street)		
City	State	Zip Code

Employer/Counsel		
Address (Number & Street)		
City	State	Zip Code

Signed this _____day of_____, _____.

Signature of Physician		
Address (Number & Street)		
City	State	Zip Code
Telephone Number of Physician		
Print or type name of Physician		

Revised 4-18-18