

SEND COPIES TO:

- 1-Workers' Compensation Court
- 1-Insurance Carrier

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

THIS SPACE FOR COURT USE ONLY

Full Name of Claimant (Injured Employee) - LAST, FIRST, MIDDLE			
Complete Address		City	State
Telephone Number		Social Security Number	
Date of Birth	Sex	Length of Employment Years _____ Months _____	
Average Weekly Wage	Occupation (job description)		Was employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>

Date of accident or last exposure	Time of accident or exposure o'clock <input type="checkbox"/> AM <input type="checkbox"/> PM	Date Employer notified	Time workday began o'clock <input type="checkbox"/> AM <input type="checkbox"/> PM
Last date employee worked	Has employee returned to work Yes <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date _____	Did the employee die Yes <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date _____	

Place of Accident or Occurrence City: _____ County: _____ State: _____	<table border="0"> <tr> <td>Cumulative Trauma:</td> <td>Single Incident Injury:</td> <td rowspan="5">Identify part(s) of body involved in injury or illness</td> </tr> <tr> <td>Carpal Tunnel <input type="checkbox"/></td> <td>Sprain/Strain <input type="checkbox"/></td> </tr> <tr> <td>Respiratory Illness <input type="checkbox"/></td> <td>Amputation <input type="checkbox"/></td> </tr> <tr> <td>Heart Attack or Stroke <input type="checkbox"/></td> <td>Heart Attack or Stroke <input type="checkbox"/></td> </tr> <tr> <td>Hearing <input type="checkbox"/></td> <td>Burn <input type="checkbox"/></td> </tr> <tr> <td>Other _____</td> <td>Other _____</td> <td>Full Name and address of Treating Physician (please be complete)</td> </tr> </table>	Cumulative Trauma:	Single Incident Injury:	Identify part(s) of body involved in injury or illness	Carpal Tunnel <input type="checkbox"/>	Sprain/Strain <input type="checkbox"/>	Respiratory Illness <input type="checkbox"/>	Amputation <input type="checkbox"/>	Heart Attack or Stroke <input type="checkbox"/>	Heart Attack or Stroke <input type="checkbox"/>	Hearing <input type="checkbox"/>	Burn <input type="checkbox"/>	Other _____	Other _____	Full Name and address of Treating Physician (please be complete)
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Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.

Employer's Insurance Carrier or Own Risk Group	Policy/Self-Insured Number
Name _____ Phone _____	Policy Period - from _____ to _____
Address _____	
Employer's Name and Complete Address	
Name _____ Phone () _____	
Address _____ City _____ State _____	
Type of business (Example: manufacturing, food service, construction)	SIC Number
Type of ownership: Private <input type="checkbox"/> State Gov't <input type="checkbox"/> County Gov't <input type="checkbox"/> Local Gov't <input type="checkbox"/>	

Upon filing this Notice of Injury, permission is given to the Administrator of the Workers' Compensation Court, the insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter relating to the notice.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income he is receiving or any change in his employment status, occurring during the period of receipt of such benefits.

I hereby declare under penalty of perjury that I have examined this notice, and 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.

Signed this _____ day of _____, 19 _____

Prepared by _____

Title _____

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO THE WORKERS' COMPENSATION COURT ON THE DATE DESCRIBED BELOW:

_____, 19 _____

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

A Form 2 must be sent to the Workers' Compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury requiring medical attention away from the work site or resulting in lost time beyond the shift.