CC-FORM-A

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

THIS SPACE FOR COMMISSION USE ONLY

In re Claim of:

Full Name of Claimant (Injured Employee)	
Claimant's Social Security Number (LAST 5 DIGITS ONLY) XXX-X_____	
Name of Employer (Respondent)	COMMISSION FILE NO.
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured	Date of Injury

CLAIMANT'S APPLICATION FOR CHANGE OF PHYSICIAN AND REQUEST FOR HEARING

[For use ONLY if the worker is NOT subject to a Certified Workplace Medical Plan (CWMP).]

Pursuant to 85A O.S. § 56(B), CLAIMANT herein respectfully requests that the above captioned matter be set for hearing on the issue of change of physician. In support of this application, claimant states as follows:

1. Claimant is not subject to a certified workplace medical plan.
2. A change of physician is sought for treatment of claimant's _____ _____ (state injured body part).
3. The name of claimant's current treating physician is _____.

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.

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.

Signed this _____ day of _____, _____.

Signature of Claimant	Print or Type Name of Attorney for Claimant, if any OBA #
Claimant's Address (Number and Street)	Signature of Attorney for Claimant
City State Zip	Claimant's Attorney's Address (Number and Street)
Claimant's Telephone Number	City State Zip
	Claimant's Attorney's Telephone Number

CERTIFICATE OF SERVICE

This is to certify that on this _____ day of _____, _____, the foregoing CLAIMANT'S APPLICATION FOR CHANGE OF PHYSICIAN AND REQUEST FOR HEARING was mailed, postage prepaid to:

Opposing Party/Counsel	Opposing Party/Counsel
Address (Number and Street)	Address (Number and Street)
City State Zip	City State Zip

_____
Signature of Claimant or Claimant's Attorney, if any