CC-FORM-71

Attach to Entry of Appearance filed by Attorney Representative

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

THIS SPACE FOR COMMISSION USE ONLY

In re claim of:

Full Name of ☐ Injured Employee ☐ Beneficiary/Guardian in Death Claim ☐ Provider
Full Name of Deceased Employee if Death Claim
Social Security Number of Injured Employee or, if Death Claim, Deceased Employee (LAST 5 DIGITS ONLY) XXX-X
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Group Self-Insurance Association

Commission File Number
Date of Injury

AUTHORIZATION FOR ATTORNEY REPRESENTATION

[Attach to entry of appearance as provided in Commission Rule 810:10-1-10(b).]

_____(name of party) designates the following attorney or law firm to serve as ☐ my ☐ our authorized representative in the above referenced matter, to receive all notices in ☐ my ☐ our behalf and to provide services in this matter, including the presentation of evidence relating to the claim, unless and until this authorization is terminated or withdrawn by further written notices or upon an order of withdrawal pursuant to the filing of a CC-Form-93 (Application and Order for Leave to Withdraw as Attorney of Record):

REPRESENTATIVE INFORMATION (Please type or print.)

Full Name of Representative (Last, First, MI)		OBA #	
Mailing Address	City	State	Zip
Email Address			
Telephone Number (Area Code, Number and Extension)			
FAX Number			
Firm Name			

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.

NOTE: Both the designated representative and the client must sign and date this Authorization for Attorney Representation.
By signing below the ☐ injured employee ☐ beneficiary/guardian in death claim ☐ provider (if an individual, or the authorized agent of the provider) ☐authorized agent of the respondent employer/carrier, who is making this designation, acknowledges the representative indicated above will represent them in the above referenced matter. By signing below, the representative accepts this designation.

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

Party's Signature ☐ Respondent Employer/Insurer ☐ Injured Employee ☐ Beneficiary/Guardian in Death Claim ☐ Provider	Date Signed
Print or Type Name of Party Signing	
Representative's Signature	Date Signed
Print or Type Name of Representative	

Revised 4-18-18