CC-FORM-3

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

WORKERS' COMPENSATION COMMISSION 1915 NORTH STILES AVENUE
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: _____		
EMPLOYEE EMAIL		

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)