CC-FORM-9

Send original to:
Workers' Compensation Commission and 1 copy to
Each Opposing Party/Counsel

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)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Group Self-Insurance Association

REQUEST FOR HEARING

Commission File Number
Date of Injury

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)

1. Issues to be tried: (Mark all applicable issues below.)
   - ☐ a. Temporary Total Disability from _____ to _____.
   - ☐ b. Medical Treatment from _____ to _____.
   - ☐ c. Permanent Partial Disability.
   - ☐ d. Permanent Total Disability.
   - ☐ e. Claim for additional compensation per 85A O.S. § 80 for Reopen on Change of Physical Condition. Has the Reopen Fee been paid? ☐ YES ☐ NO
   - ☐ f. Change of Physician for a worker covered by a Certified Workplace Medical Plan (CWMP). (**Note:** File a CC-Form-A to set a Request for Change of Physician when the worker is NOT covered by a CWMP.)
   - ☐ g. Change of Case Manager for a worker not covered by Certified Workplace Medical Plan (CWMP).
   - ☐ h. Liability of Multiple Injury Trust Fund.
   - ☐ i. Rate: TTD_____PPD_____ PTD _____ AWW_____.
   - ☐ j. Death Benefits.
   - ☐ k. MFDR Form 19 (Provider Request for Medical Fee Dispute Resolution). Was the MFDR Form 19 filed previously with the Commission? ☐ YES ☐ NO
   - ☐ l. Other (SPECIFY)_____.

(***ALL DEPOSITIONS OF MEDICAL EXPERTS SHALL BE COMPLETED PRIOR TO THE HEARING BEFORE THE ADMINISTRATIVE LAW JUDGE***.)

2. List the names of all witnesses who may be called at hearing:_____
   _____
3. List all exhibits to be introduced at hearing: _____
   _____
4. Requestor hereby certifies that a copy of the medical report written by Dr. _____and dated _____ was mailed, together with a copy of the REQUEST FOR HEARING, to the Opposing Party/Counsel.

(REFER TO COMMISSION RULES ON THE EXCHANGE OF EXHIBITS.) Do <u>NOT</u> attach a copy of the medical report when filing the CC-Form-9 with the Workers' Compensation Commission.

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 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.

Signed this _____day of_____,_____.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party/Counsel		
Address (Number & Street)		
City	**State**	**Zip Code**

Signature of ☐ **Respondent** ☐ **Claimant** ☐ **Provider** ☐ **Counsel for Requestor**		
Address (Number & Street)		
City	**State**	**Zip Code**
Telephone # of Filing Party		
Print or type Name of Attorney		**OBA #**

Revised 4-18-18