FORM 3

Send original and 4 copies to:
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

THIS SPACE FOR COURT USE ONLY

Name of Claimant (Injured Employee)
Name of Employer
Court Use Only

Please check appropriate box
☐ I. Original Filing

☐ II. Amends Previously Filed Form 3. Must clearly state whether amendment is in addition to, or substitute for, prior information.)

EMPLOYEE'S FIRST NOTICE OF ACCIDENTAL INJURY AND CLAIM FOR COMPENSATION

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or In-State Toll Free (800) 522-8210.

WCC FILE NO.

(Please type or print)

EMPLOYEE NAME (Last, First, Middle):	Social Security #:	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 Accident, or as applicable, Date of Termination From Employment if a Cumulative Trauma 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 Accidental Injury and 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 "YES", you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund. A claim against the Multiple Injury Trust Fund may be commenced by filing a "Form 3F" with the Workers' Compensation Court.

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:

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall within seven (7) days report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA#
Mailing Address:	
City	State Zip
Telephone #: ( )	

Upon filing this Notice of Accidental Injury And Claim For Compensation, 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. The permission granted to the above persons authorizes them access to medical records pursuant to 76 O.S., §19, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination. This form is not intended for use as a medical authorization. Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.

I declare under penalty of perjury that I have examined this notice and claim for compensation and all statements contained herein are true, correct and complete to the best of my knowledge and belief.

Signed this _____ day of _____ , _____

Signature of Attorney for Claimant

Signature of Claimant (must be signed by claimant)

08/26/11