FORM 9

Send original to
Court of Existing Claims and 1 copy to
Each Opposing Party/Counsel

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

In re claim of:

Full Name of Claimant (Injured Employee)
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Group Self-Insurance Association

MOTION TO SET FOR TRIAL

WCC FILE NO.
Date of Injury

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (918) 581-2714.

(Please Type or Print)

1. Issues to be tried: (Circle all applicable issues below.)
   a. Temporary Total Disability from _____ to _____.
   b. Medical Treatment from _____ to _____.
   c. Permanent Partial Disability/Permanent Partial Impairment.
   d. Permanent Total Disability.
   e. Motion to Reopen on Change of 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 Form A to set a request for Change of Physician when there is no 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/PPI_____AWW_____.
   j. Death Benefits.
   k. Appeal from Form 18 Order.
   l. Form 19 (Request For Payment of Health or Rehabilitation Services). Was the Form 19 filed previously? ☐ YES ☐ NO
   m. Other (SPECIFY)_____.

   (***ALL DEPOSITIONS OF MEDICAL EXPERTS SHALL BE COMPLETED PRIOR TO TRIAL.***)
2. List the names of all witnesses who may be called at trial:_____
   _____
3. List all exhibits to be introduced at trial: _____
   _____
4. Requestor hereby certifies that a copy of the medical report written by Dr. _____and dated _____ was mailed, together with this motion, to Opposing Party/Counsel. (Refer to Court rules regarding the exchange of exhibits.) Do **NOT** attach a copy of the medical report when filing the Form 9 with the Court of Existing Claims.

I declare under penalty of perjury that I have examined this motion and all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

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

Signed this_____day of_____,_____.

Signature of Requesting Party ☐ **claimant** ☐ **resp.** ☐ **med/rehab provider**
Address (Number & Street)
City **State** **Zip Code**
Telephone # of Requesting Party
Print or type name of Attorney **OBA #**

Rev. 06/24/2015