CC-FORM-2 Applicable to Injuries /Deaths Occurring On or After 2/1/14

WORKERS' COMPENSATION COMMISSION 1915 NORTH STILES AVENUE STE 231

OKLAHOMA CITY, OK 73105

Send original to Workers' Compensation Commission and 1 copy to Insurance Carrier						
Please type or print. Enter all dates in MM/DD/YY format.		EMPLOYE	R'S FIRST NOTICE OF INJURY			
Full Name of Employee - LAST, FIRST, MIDDLE			Employee Email Address			
Complete Address	City	State	Zip	-		
Telephone Number Employee's Soc XXX-XX			ecurity Number (LAST 4 DIGITS ONLY)	-		
Date of Birth	Sex		Length of Employment: Years Months Date of Hire:			
Average Weekly Wage	Occupation (job descriptio	n)	·	Was employment agreement made in Oklahoma? YES NO		

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.

Date of accident or last exposure	Time of accident or exposur	re oʻclock AM 🗖 PM 🖡	Dat	e Employer Notified	Time workday bega	n oʻclock AM	рм			
Last date employee worked	Has employee returned to v	work? If yes, on what date ?	•	Did the employee die?	ves, on what date ?					
OSHA Log Case #		Place of Accident or Occurren City:	nce	County:		State:				
Injury Resulted from: Single Incident	Cumulative Tra	auma 🔲 Occupationa	al Disease							
Nature of Injury or Illness Does employee participate in a certified workplace medical plan: YES NO If yes, name of CWMP:										
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.										
Identify part(s) of body involved in injury or i	llness									
Full Name and address of Treating Physician	(please be complete)									
Employer's Insurance Carrier or Own Risk Gr	oup			Policy/Self-Insured Numb	er					
Name		Phone		Policy Period: From		То				
Address			City		State	Zip				
Employer's Name and Complete Address										
Name Address		Federal ID#	City	Phone #	State	Zip				
Type of business (Example: manufacturing, 1	food service, construction)					NAICS Number				
Type of Ownership: Private	State Gove	rnment	County Govern	ment	Local Government					

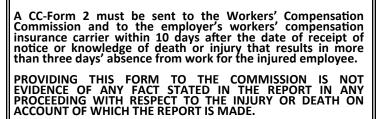
Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for 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 hereby declares under PENALTY OF PERJURY that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this CC-Form 2 was sent to the Workers' Compensation Commission and a copy thereof to the employer's insurer on the date noted below:

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Date-



THIS SPACE FOR COMMISSION USE ONLY