

FORM 2

Send original to
Workers' Compensation Court and 1 copy to
Insurance Carrier
Please type or print. Enter all dates in MM/DD/YY format.

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

EMPLOYER'S FIRST NOTICE OF INJURY

| | | | |
|---|------------------------------|--|--|
| Full Name of Employee - LAST, FIRST, MIDDLE | | | |
| Complete Address | | City | State Zip |
| Telephone Number | | Social Security Number | |
| Date of Birth | Sex | Length of Employment Years _____ Months _____ | |
| Average Weekly Wage | Occupation (job description) | | Was employment agreement made in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/> |

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

| | | | |
|---|--|--|---|
| Date of accident or last exposure | Time of accident or exposure _____ o'clock AM <input type="checkbox"/> PM <input type="checkbox"/> | Date Employer Notified | Time workday began _____ o'clock AM <input type="checkbox"/> PM <input type="checkbox"/> |
| Last date employee worked | Has employee returned to work? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date _____ | Did the employee die? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date _____ | |
| OSHA Log Case # | Place of Accident or Occurrence City: _____ County: _____ State: _____ | | |
| Injury Resulted from: Single Incident <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/> | Does employee participate in a certified workplace medical plan: YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, name of CWMP: _____ | | |
| Nature of Injury or Illness | | | |
| 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 illness | | | |
| Full Name and address of Treating Physician (please be complete) | | | |
| Employer's Insurance Carrier or Own Risk Group | | Policy/Self-Insured Number | |
| Name | Phone | Policy Period—from _____ to _____ | |
| Address | City | State | Zip |
| Employer's Name and Complete Address | | Federal ID# | Phone # |
| Name | City | State | Zip |
| Type of business (Example: manufacturing, food service, construction) | | | SIC Number |
| Type of Ownership: Private <input type="checkbox"/> | State Government <input type="checkbox"/> | County Government <input type="checkbox"/> | Local Government <input type="checkbox"/> |

Upon filing this Notice of Injury, 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.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly 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.

I hereby declare under penalty of perjury that I have examined this notice, 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.

Signed this _____ day _____, _____ I hereby certify that this Form 2 was sent to the Workers' Compensation Court and a copy thereof to the insurer on the date described below:

Prepared by _____

Title _____

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

A Form 2 must be sent to the Workers' Compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise. Form 2s filed with the Workers' Compensation Court are confidential and not subject to public disclosure except as authorized by law.