CC-FORM-2

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

WORKERS' COMPENSATION COMMISSION 1915 NORTH STILES AVENUE

OKLAHOMA CITY, OK 73105

Send original to Workers' Compensation 1 copy to Insurance Carrier	n Commission and			
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 Social Security Number (LAST 4 DIGITS ONLY)		-
Date of Birth	Sex		Length of Employment: YearsMonths Date of Hire:	-
Average Weekly Wage	Occupation (job description)			YES NO 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 exposu			Date Employer Notified	Time workday bega	n oʻclock AM	PM
Last date employee worked	Has employee returned to v	work? If yes, on what date ?		Did the employee die?	yes, on what date ?		,
OSHA Log Case #		Place of Accident or Occurr City:	ence	County:		State:	
Injury Resulted from: Single Incident	Cumulative Tra	auma 🔲 Occupatio	onal Disease				
Nature of Injury or Illness				nployee participate in a certified work ame of CWMP:	place medical plan:	yes 🔲 no 🗖	
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,	food service, construction)					NAICS Number	
Type of Ownership: Private	State Gove	rnment	County Gov	ernment	Local Government		

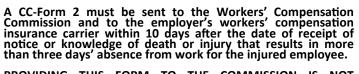
Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for 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:

Signed	
- 0	Signature of Preparer
D	
Ву	Name and Title of Preparer (Please Print)
Telephone	e Number
reiepiioiie	Area Code and Number

Date-



THIS SPACE FOR COMMISSION USE ONLY

PROVIDING THIS FORM TO THE COMMISSION IS NOT EVIDENCE OF ANY FACT STATED IN THE REPORT IN ANY PROCEEDING WITH RESPECT TO THE INJURY OR DEATH ON ACCOUNT OF WHICH THE REPORT IS MADE.