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-B (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

COURT CLAIM #

(Please type or print)

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

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 Last Exposure:	Injury resulted from: Single Incident ☐ Cumulative Injury ☐		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:		

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:

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. Any claim made for benefits for combined disabilities must be commenced by filing a "Form 3-E" or "Form 3-F", as appropriate, with the Workers' Compensation Court.

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

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. The permission granted to the above named individuals or their designees authorizes them access to medical records pursuant to Section 19 of Title 76 of the Oklahoma Statutes, 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.

Signed this ________________ day of __________________________ , _________

Signature of Claimant (must be signed by claimant)

Signature of Attorney for Claimant

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

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