CC-FORM-2 Applicable to Injuries /Deaths Occurring On or After 2/1/14 Send original to Workers' Compensation Commission and 1 copy to Insurance Carrier Please do not send original to Workers' Compensation Commission. Please type or print. Enter all dates in MM/DD/YY format.		WORKERS' COMPENSATION COMMISSION 1915 NORTH STILES AVENUE STE 231 OKLAHOMA CITY, OK 73105 EMPLOYER'S FIRST NOTICE OF INJURY		J	THIS SPACE FOR COMMISSION USE C
Full Name of Employee - LAST, FIRST, MIDI	1 1 1		Employee Email Address		
Complete Address	City	State	Zip	_	
Telephone Number		Employee's Co	cial Security Number(LAST 5 DIGITS ONLY)		

	XXX-X		
Date of Birth	Sex	Length of Employment: YearsMonths Date of Hire:	
Average Weekly Wage	Occupation (job description)		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.

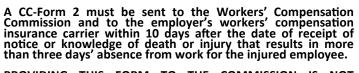
Date of accident or last exposure	Time of accident or exposure o'clock		Date Employer Notified	Time workday began oʻclock AM	рм
Last date employee worked	Has employee returned to work?		Did the employee die?		
	YES NO If yes,	on what date ?	YES D NO D If y	ves, on what date ?	(
OSHA Log Case #	Place City	of Accident or Occurrence :	County:	State:	
Injury Resulted from: Single Incident	Cumulative Trauma	Occupational Diseas	e 🗖		
Nature of Injury or Illness			Does employee participate in a certified workp If yes, name of CWMP:	olace medical plan: YES NO	
Describe activities when injury occurred with	details of how event occurred. Inc	lude object or substance which	directly injured the employee.		
Identify part(s) of body involved in injury or il	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		Federal ID#	Phone #		
Address		City		State Zip	
Type of business (Example: manufacturing, f	food service, construction)			NAICS Number	
Type of Ownership: Private	State Governmen	it 🗌 Cor	unty Government	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		
Signed	Signature of Preparer	
By		
By	Name and Title of Preparer (Please Print)	
Telephone Number-		
	Area Code and Number	
Date		



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.