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

THIS SPACE FOR COMMISSION USE ONLY

EMPLOYER'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 5 DIGITS ONLY)
XXX-X_____

Date of Birth

Sex

Length of Employment: Years _____ Months _____
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 AM ☐ PM ☐

Date Employer Notified

Time workday began o'clock AM ☐ PM ☐

Last date employee worked

Has employee returned to work?
YES ☐ NO ☐ If yes, on what date ? _____

Did the employee die?
YES ☐ NO ☐ If yes, on what date ? _____

OSHA Log Case #

Place of Accident or Occurrence
City: County: State:

Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational 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 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

Name Federal ID# Phone #

Address City State Zip

Type of business (Example: manufacturing, food service, construction)

NAICS Number

Type of Ownership: Private ☐ State Government ☐ County 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 _____
Signature of Preparer

By _____
Name and Title of Preparer (Please Print)

Telephone Number _____
Area Code and Number

Date _____

A CC-Form 2 must be sent to the Workers' Compensation Commission and to the employer's workers' compensation insurance carrier within 10 days after the date of receipt of notice or knowledge of death or injury that results in more than three days' absence from work for the injured employee.

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.

Submit by email