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, OKLAHOMA 73105-4918

EMPLOYER'S FIRST NOTICE OF INJURY

THIS SPACE FOR COURT USE ONLY

Full Name of Claimant (Injured 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 ☐ NO ☐

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.

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 ______

Place of Accident or Occurrence
City: County: State:

Injury Resulted From: Single Incident ☐ Cumulative Trauma ☐

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

Employer's Name and Complete Address
Name | Federal ID# | Phone
Address | City | State | Zip

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

Type of ownership: Private ☐ State Gov't ☐ County Gov't ☐ Local Gov't ☐

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 he is receiving or any change in his 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 of ______, ______

Prepared by______

Title ______

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:

______, ______

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.