# CC-FORM-2

**USE BEGINNING 2/1/14 REGARDLESS OF DATE OF INJURY**

Send original to Workers' Compensation Commission and 1 copy to Insurance Carrier

***Please type or print. Enter all dates in MM/DD/YY format.***

**WORKERS' COMPENSATION COMMISSION**
1915 NORTH STILES AVENUE
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 4 DIGITS ONLY) XXX-XX-_____ | | |
| 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) 522-8760 or In-State Toll Free (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 ?_____ | |
| 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.**