

**CC-FORM-4****OKLAHOMA WORKERS' COMPENSATION COMMISSION**

FOR COMMISSION USE ONLY

Send original to:

Workers' Compensation Commission and 1  
copy to Employee or Beneficiaries1915 NORTH STILES AVENUE  
OKLAHOMA CITY, OKLAHOMA 73105  
(405) 522-5308 or In-State Toll Free (855) 291-3612**REPORT OF COMPENSATION PAID/SUSPENSION OF PAYMENTS** **AMENDED REPORT** **Closing Report** **Death/PTD Maximum Liability** **Report of Payment Suspension** **Update Report (additional payments only)**

Commission File No.	Carrier Claim No.	Full Employee Name (Last, First, MI)	Employee Social Security No. (Last 4 digits only)	
Employer Name		City	State	Zip Code
Carrier or Self-Insured Name		Claims Office Location (mailing address)		

**DISABILITY INFORMATION**

Date of Injury	Last Day Employee Worked	Date Employee Able to RTW	Return-to-Work (RTW) Date
Total days worked between injury and date able to RTW: _____			

**COMPENSATION INFORMATION:**

<b>COMPENSATION PAYMENTS MADE:</b>		(9) Defense Attorney Fees	_____
(1) TTD Weeks _____ Days _____ \$ _____		(10) Other (Compensation Related)	_____
(2) TPD Weeks _____ Days _____		(11) Hospital Expenses	_____
(3) PPD Weeks _____ Days _____		(12) Medical Expenses	_____
(4) _____ Weeks PTD		(13) Drugs, Medicine	_____
(5) _____ Weeks for Death		(14) Funeral Expenses	_____
(6) Lump Sum payment		(15) Rehabilitation	_____
(7) Joint Petition Settlement		(16) Other (Expense Related)	_____
(8) Claimant Attorney Fees		(1 - 16) GRAND TOTAL	_____

**SUSPENSION OF PAYMENTS OF COMPENSATION**

Date of Suspension of Compensation: \_\_\_\_\_ Reason for Suspension: \_\_\_\_\_

\_\_\_\_\_

Compensation paid through \_\_\_\_\_ (date).

**CERTIFICATION**

I certify under PENALTY OF PERJURY that the foregoing is a complete and accurate report according to the records of the insurer pertaining to payments of compensation and suspensions of payment information. I further certify that a copy of this report or equivalent information has been provided to the employee or beneficiaries.

Signature	Printed or Typewritten Name	Title	Date

## CC-FORM-4

(Report of Payment)

**Questions about the CC-Form-4, or general information or assistance on completing or filing a CC-Form-4, may be directed to the Workers' Compensation Commission Counselor Division, (405) 522-5308 or In-State Toll Free (855) 291-3612.**

**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.