FORM JP-APPENDIX

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

JOINT PETITION SETTLEMENT APPENDIX

In re Claim of: (Please type or Print ALL information legibly in ink.)

Full Name of Injured Employee
Injured Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX– XX-_____
Name of Employer
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

Commission File Number
Date of Injury

Use and attach to a CC-Joint Petition ONLY IF the Joint Petition Settlement seeks to settle and determine SOME, BUT NOT ALL, issues and matters in the claim. Identify the outstanding issues that are subject to the Commission's continuing jurisdiction. *NOTE: The original and five (5) copies of the Joint Petition Settlement with Appendix attached are required when the settlement order is submitted to the Workers' Compensation Commission for filing.*

By signing below, each party affirms that they have read and understand the provisions of this JOINT PETITION SETTLEMENT APPENDIX, declares under penalty of perjury that all statements are true and accurate to the best of their knowledge and belief, and understands that the Joint Petition Settlement Appendix, if approved by the Workers' Compensation Commission, is conclusive, final and binding on all parties involved.

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.

_____
Name of Claimant

X_____
Signature of Claimant DATE

_____
Address of Claimant

_____
Type or Print Name of Claimant's Attorney, if any OBA#

X_____

_____
Name of Respondent

_____
Name of Insurance Carrier or Own Risk Group

_____
Type or Print Name of Respondent/Insurer Attorney OBA#

X_____
Signature of Respondent/Insurer Attorney DATE

Created 2-2-16