CC-FORM-10

Send original to:
Workers' Compensation Commission and 1 copy to Claimant or the Claimant's Attorney of Record, if any

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

THIS SPACE FOR COMMISSION USE ONLY

In re claim of:

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

ANSWER AND NOTICE OF CONTESTED ISSUES

COMMISSION FILE NO.
Date of Injury

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.

YES **NO** (Please Type or Print)

_____ _____ 1. Was claimant at the time of the alleged injury, an employee of the respondent named above?
_____ _____ 2. Was claimant covered by the Administrative Workers' Compensation Act, Title 85A of the Oklahoma Statutes?
_____ _____ 3. Did claimant sustain an accidental injury, cumulative trauma or suffer an occupational disease or illness arising out of and in the course of the employment?
_____ _____ 4. Has claimant filed a claim for compensation (i.e. a CC-Form-3 or CC-Form-3B) within the statutory period of time?
_____ _____ 5. Did respondent, at the time of the alleged injury, have an own-risk permit or a compensation insurance policy with the carrier named above?
_____ _____ 6. Did claimant timely notify respondent of the injury?
_____ _____ 7. Has claimant been provided medical treatment?
_____ _____ 8. Has respondent commenced payment of temporary total disability payments to claimant?
Temporary total disability has been paid to claimant from _____ to _____ for a total of _____ weeks in the total sum of $_____ .
_____ _____ 9. Has respondent selected a treating physician?
Name of treating physician: _____ .

(ALL DEPOSITIONS OF MEDICAL EXPERTS SHALL BE COMPLETED PRIOR TO THE HEARING BEFORE THE ADMINISTRATIVE LAW JUDGE)

_____ _____ 10. Is rate an issue? Claimant's compensation rate: TTD _____ PPD_____.

11. State all affirmative defenses: _____
_____

12. List the names of all witnesses who may be called by respondent at hearing: _____
_____

13. List all exhibits to be introduced at hearing: _____
_____

14. Respondent hereby certifies that a copy of the medical report written by Dr. _____, and dated _____, was mailed, together with a copy of this ANSWER AND NOTICE, to the Opposing Party/Counsel.

(LIST ON A SEPARATE SHEET, ADDITIONAL WITNESSES, EXHIBITS AND MEDICAL EVIDENCE)
If compensability of a claim is contested, the respondent shall complete discovery and secure a medical evaluation of the claimant within sixty (60) days of the claimant's filing of a claim for compensation. 85A O.S., §111(B).

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 declare under PENALTY OF PERJURY that they have examined all statements contained herein, and to the best of their knowledge and belief, they are true, correct and complete.

Signed this _____day of_____,_____.

THE RESPONDENT/INSURER HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party/Counsel		
Address (Number & Street)		
City	**State**	**Zip Code**

Signature of ☐ **Respondent** ☐ **Insurer** ☐ **Counsel for Respondent/Insurer**		
Address (Number & Street)		
City	**State**	**Zip Code**
Telephone # of Filing Party		
Print or type Name of Attorney		**OBA #**

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