CC-FORM-17

Send original to:
Workers' Compensation Commission
Attention: Health Services Division

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

THIS SPACE FOR COMMISSION USE ONLY

PART I. Physicians providing treatment under the workers' compensation laws of this state or applying to serve as a Workers' Compensation Commission certified Independent Medical Examiner MUST complete Part I of this form. **FAILURE TO DO SO IS GROUNDS FOR DISQUALIFICATION OF THE PHYSICIAN FROM PROVIDING TREATMENT UNDER THE WORKERS' COMPENSATION LAWS OF THIS STATE.** Any change in information must be reported to the Commission as soon as practicable after such change by filing another CC-Form-17 marked "AMENDED". All reported information must be updated annually.

PART II. If a physician or an entity in which the physician has a financial interest, other than an ownership interest of less than 5% in a publically traded company, provides implantable devices, that relationship shall be disclosed to the patient, employer, insurance company, third party administrator, certified workplace medical plan, case manager, and legal counsel for the worker and employer/carrier. The disclosure may be made directly to those persons OR by completing Part II of this form.

ALL INFORMATION SUBMITTED TO THE COMMISSION MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW. Direct questions to the Commission's Health Services Division, (405) 522-3222 or In-State-Toll Free (855) 291-3612.

PHYSICIAN DISCLOSURE STATEMENT

(Please type or print)

Physician Information		
	Physician Name:	Professional License #:
	Address:	
	City: State: Zip:	

PART I. Disclosure Of Ownership Or Interests In Entities Other Than The Physician's Primary Place of Business

If you are a physician providing treatment under the workers' compensation laws of this state or applying as a Workers' Compensation Commission certified Independent Medical Examiner, you must disclose any ownership or interest in any pharmacy, health care facility, business or diagnostic center that is not the physician's primary place of business. This includes, but is not limited to, disclosure of any leasing agreement between the physician and entity. (Attach supplemental pages as necessary. If you have no disclosures, state "NONE".)

Name of Entity: Employee Leasing Arrangement? ☐ Yes ☐ No	Name of Entity: Employee Leasing Arrangement? ☐ Yes ☐ No
Address:	Address:
City: State: Zip:	City: State: Zip:

PART II. Disclosure Regarding Implantable Devices

If a physician or an entity in which the physician has a financial interest, other than an ownership interest of less than 5% in a publically traded company, provides implantable devices, that relationship shall be disclosed to the patient, employer, insurance company, third party administrator, certified workplace medical plan, case manager, and legal counsel for the worker and employer/carrier. The disclosure may be made directly to those persons OR by completing Part II of this CC-Form-17. (Attach supplemental pages as necessary.)

Physician Provides Implantable Devices? ☐ Yes ☐ No	Physician Provides Implantable Devices? ☐ Yes ☐ No
Physician Has Financial Interest, Other Than Ownership Interest of Less Than 5% In A Publically Traded Company, That Provides Implantable Devices? ☐ Yes ☐ No (If yes, provide name and address of entity below.)	Physician Has Financial Interest, Other Than Ownership Interest of Less Than 5% In A Publically Traded Company, That Provides Implantable Devices? ☐ Yes ☐ No (If yes, provide name and address of entity below.)
Name of Entity:	Name of Entity:
Address:	Address:
City: State: Zip:	City: State: Zip:

I declare under penalty of perjury that I have examined all statements contained herein and they are true, correct and complete, to the best of my knowledge and belief. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

Signed this _____ day of _____, _____ _____
Signature of Physician

Revised 2-2-16