CC-FORM-3F

USE FOR SUBSEQUENT INJURY OCCURRING ON OR AFTER FEBRUARY 1, 2014

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

THIS SPACE FOR COMMISSION USE ONLY

Send original to:
Workers' Compensation Commission and 1 copy to the Multiple Injury Trust Fund and 1 copy to the Oklahoma State Treasurer

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-3F. **(Circle the change, in blue or black ink, and identify whether it adds to or replaces the prior information.)**

Full Name of Claimant (Injured Employee)

MULTIPLE INJURY TRUST FUND
P.O. Box 528801
Oklahoma City, OK 73152

OKLAHOMA STATE TREASURER
2300 N. Lincoln Boulevard, Room 217, State Capitol Bldg.
Oklahoma City, OK 73105

EMPLOYEE'S NOTICE OF CLAIM FOR BENEFITS FROM THE MULTIPLE INJURY TRUST FUND

COMMISSION FILE NO.

(Please type or print)

FULL NAME OF EMPLOYEE (Last, First, Middle)	Social Security # (LAST 5 DIGITS ONLY) XXX-X	Phone: ( )
Mailing Address (include City, State, & Zip)	Date of Birth: Age:	Sex:
Commission File Number for most recent injury / Date of Injury	Date of Order	Percentage of Disability Awarded and Body Part
Amount of Joint Petition Settlement or Other Settlement	Rate of weekly compensation for permanent partial disability at the time of the most recent injury	

PRIOR

Commission File No.	Date of Injury	Date of Order	% of Disability & Body Part	Amount of Joint Petition Settlement or Other Settlement

Are weekly benefits still being paid on any of the above orders? YES ☐ NO ☐ If so, when are benefits expected to terminate? _____

List and describe fully any other pre-existing disability for which no award has been made. (Pre-existing disability means any obvious and apparent disability resulting from any cause, which disability is obvious and apparent from observation of a person who is not skilled in the medical profession.)

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's Attorney, if represented:

Type or Print Name of Attorney:	OBA #
Mailing Address:	
City:	State: Zip:
Telephone #: ( )	
Email:	

The undersigned declare under PENALTY OF PERJURY that they have examined this *Notice of Claim for Benefits from the Multiple Injury Trust Fund* and all statements contained herein are true, correct and complete, to the best of their knowledge and belief. Additionally, the undersigned certify that a true and correct copy of this *Notice of Claim* was mailed to the MULTIPLE INJURY TRUST FUND and to the OKLAHOMA STATE TREASURER on the date noted below.

Signed this _____day of_____ , _____.

_____
Signature of Claimant (Must be signed by Claimant)

_____
Signature of Attorney for Claimant (if any)

Revised 4-1-21