CC-FORM-V	OKLAHOMA WORKERS' COMPENSATION COMMISSION 1915 NORTH STILES AVENUE OKLAHOMA CITY, OKLAHOMA 73105 (405) 522-5308 or In-State Toll Free (855) 291-3612	FOR COMMISSION USE ONLY

VERIFICATION OF PERMANENT TOTAL DISABILITY

(Please print legibly in ink.)

Full Name of Employee: _____

Address _____

_____

City State Zip

Commission File No.: _____ Name of Employer: _____

Employee's Social Security No. (Last 5 digits only.): XXX-X_____ Date of Injury: _____

I, _____, do hereby certify and affirm under PENALTY OF PERJURY that I am permanently and totally disabled due to my work-related condition and not capable of gainful employment. Also, I am not presently, nor have I been, gainfully employed since I became permanently and totally disabled. I further certify that a copy hereof was sent to the insurance carrier or self-insured employer on the date and at the address noted below.

Insurance Carrier/Self-Insured Employer/Counsel		
Address (Number & Street)		
City	**State**	**Zip Code**

Dated this _____day of_____, 2_____.

_____

Signature

State of _____

County of _____

SUBSCRIBED AND SWORN TO before me, a Notary Public, on this _____ day of _____, _____.

_____

NOTARY PUBLIC

My Commission Expires:

_____

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.