Before the Workers' Compensation Commission of the State of Oklahoma

In re claim of:

_____, Claimant	)	Commission File #: _____
_____, Respondent	)	Claimant's Social Security Number XXX-X_____
_____, Insurance Carrier	)	- (LAST 5 DIGITS ONLY)

CERTIFICATE TO JOINT PETITION

1. The claimant certifies that the Respondent has been notified of all medical providers who have provided medical treatment, including physical therapy, as a result of the accidental injury or occupational disease or illness while employed by Respondent. A list of all medical providers who have provided treatment is attached hereto as Exhibit A.

   Further, the Claimant represents and agrees to notify all future medical providers for the accidental injury or occupational disease or illness while employed by the Respondent that the claim against the Respondent has been fully settled by Joint Petition Settlement.

   _____
   Claimant

2. The Respondent certifies that a copy of the Joint Petition Settlement will be provided to all known medical providers, including physical therapists, who have provided treatment to the claimant, within ten (10) days of the settlement. The Respondent shall also notify the medical providers that the Joint Petition Settlement specifies that the Respondent will not be responsible for treatment rendered after the date of the Joint Petition Settlement.

   _____
   Respondent

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.

EXHIBIT "A" TO CERTIFICATE TO JOINT PETITION

The following Medical Providers have provided medical treatment, including physical therapy, as a result of the accidental injury or occupational disease or illness while employed by Respondent:

Name	Address, City, State, Zip