FORM JP-APPENDIX

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

THIS SPACE FOR COMMISSION USE ONLY

IOINT	PETITION	SFTTI	EMENT	APPENDIX
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re Claim of: (Please type or Print ALL information legibly in ink.)	
'ull Name of Injured Employee	
njured Employee's Social Security Number (LAST 5 DIGITS ONLY)	
XXX- X	
lame of Employer	Commission File Number
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insur Dwn Risk Group, Uninsured	ured or Date of Injury
ssues and matters in the claim. Identify the outstanding issue	etition Settlement seeks to settle and determine SOME, BUT NOT ALL, uses that are subject to the Commission's continuing jurisdiction. NOTE: ith Appendix attached are required when the settlement order is submitted to
	stand the provisions of this JOINT PETITION SETTLEMENT APPENDIX, declares the best of their knowledge and belief, and understands that the Joint Petition mmission, is conclusive, final and binding on all parties involved.
	Any person or entity who makes any material false statement or representation, tion, or who employs any device, scheme, or artifice, or who aids and abets any II be guilty of a felony."
Any person who commits workers' compensation fraud, upon convict	ction, shall be guilty of a felony punishable by imprisonment, a fine or both.
Name of Claimant	Name of Respondent
X	Name of Insurance Carrier or Own Risk Group
Address of Claimant	Type or Print Name of Respondent/Insurer Attorney OBA#
Type or Print Name of Claimant's Attorney, if any OBA#	XSignature of Respondent/Insurer Attorney DATE
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