CC-FORM-10C

Send original to:
Workers' Compensation Commission and 1 copy to Claimant/Claimant's Counsel

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

THIS SPACE FOR COMMISSION USE ONLY

In re claim of:

Full Name of Injured Employee (Claimant)

Claimant's Social Security Number (LAST 4 DIGITS ONLY)
XXX-XX-_____

Name of Employer (Respondent)

Employer Federal Employer ID No.

Claims Office Name, Address and Phone

COMMISSION FILE NO. (Must be filled out)

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."

Address of Employee (Claimant):	Number & Street	City	State	Zip Code
Address of Employer (Respondent):	Number & Street	City	State	Zip Code

NOTE: Mediation is available to help resolve certain workers' compensation disputes. For information, call (405) 522-5308 or In-State Toll Free (855) 291-3612.

EMPLOYER'S RESPONSE TO CLAIM FOR WORKERS' COMPENSATION DISCRIMINATION OR RETALIATION

Pursuant to 85A O.S., §7, and in response to the Claimant's CC-Form-3C (Claim for Workers' Compensation Discrimination or Retaliation), the Respondent hereby submits its answer and defenses.

YES **NO** (Please Type or Print)

_____ _____ 1. Does the Respondent generally deny that Claimant was subjected to any wrongful discharge or any other wrongful adverse employment action?

_____ _____ 2. Are all of the allegations made in the Claimant's CC-Form-3C denied except as otherwise specifically admitted herein?

3. State all allegations specifically denied and the basis for such denial. *(Attach additional pages if needed.)*: _____

4. State all allegations specifically admitted. *(Attach additional pages if needed.)* _____

5. State all defenses: _____

6. List the names of all witnesses who may be called by the Respondent at hearing: _____

7. List all exhibits to be introduced at hearing: _____

(LIST ON A SEPARATE SHEET, ADDITIONAL WITNESSES, EXHIBITS AND EVIDENCE)

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

The undersigned declare under PENALTY OF PERJURY that they have examined all statements contained herein, and to their best knowledge and belief, they are true, correct and complete.

Signed this _____ day of_____,_____.

Signature of ☐ **Respondent** ☐ **Insurer** ☐ **Counsel for Respondent/Insurer**

Address (Number & Street)

City **State** **Zip Code**

Print or type name of Attorney **OBA #**

THE RESPONDENT HEREBY CERTIFIES THAT A COPY HAS BEEN SENT TO:

Opposing Party/Counsel

Address (Number & Street)

City **State** **Zip Code**

Revised 1-14-16