CC-FORM-100

WORKERS COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OKLAHOMA 73105

THIS SPACE FOR COMMISSION USE ONLY

Send original and 3 copies to:
Workers' Compensation Commission

In re claim of:

Full Name of Claimant (Injured Employee)
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-insured or Own Risk Group

CLAIMANT'S APPLICATION AND ORDER FOR DISMISSAL

COMMISSION FILE NO.
Date of Injury

The claimant moves to DISMISS the claim noted above as provided in 85A O.S. §108 and Commission Rule 810:10-5-85(c). In support thereof, the claimant states:

YES	NO	Please mark the appropriate YES/NO response to the left of each numbered question.
☐	☐	1. The filing fee of $140.00 has been paid and a receipt showing payment is attached to this application. *(Payment of the fee is required before the dismissal is effective. 85A O.S., §108.)*
☐	☐	2. The claimant is represented by counsel.
☐	☐	*3.* A permanent total disability order, permanent partial disability order, or Joint Petition Settlement has been entered. *(An order of dismissal is allowed at any time before final submission of the case to the Commission for decision. 85A O.S., §108.)*
☐	☐	4. This request is for a dismissal with prejudice. *(Before entering an order for dismissal with prejudice, the Commission may require an evidentiary hearing.)*

Note: If a workers' compensation claim is timely filed and then dismissed WITHOUT prejudice, the claim may be refiled within one (1) year from the date the Order of Dismissal Without Prejudice is filed, even if the limitations period has run.

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

I declare under PENALTY OF PERJURY that I have examined all statements contained herein and they are true, correct and complete, to the best of my knowledge and belief.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party(ies)
Address (Number & Street)
City **State** **Zip Code**

Claimant
Address (Number & Street)
City **State** **Zip Code**
Telephone # of Claimant

Signed this _____ day of _____, _____

Signature of Claimant
Print or type name of Attorney for Claimant, if any **OBA #**
Signature of Attorney of Claimant, if any

IT IS THEREFORE ORDERED, for good cause shown, that the above captioned claim is dismissed :
☐ *With Prejudice* ☐ *Without Prejudice*

The filing of this order does not adjudicate the rights of any health care provider that has provided reasonable and necessary medical care to the claimant for a work related injury.

BY ORDER OF _____ _____
Administrative Law Judge **Date of Order**

Revised 2-2-16