CC-FORM-211

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

THIS SPACE FOR COMMISSION USE ONLY

Send original and 4 copies to Workers' Compensation Commission
and 1 copy to the Qualified Employer

Please type or print. Enter dates in MM/DD/YY format.

Full Name of Claimant Aggrieved by Adverse Benefit Determination of the Appeals Committee	
Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____	Date of Injury/Death
Name of Qualified Employer (Respondent)	Date Claimant Received the Adverse Benefit Determination of the Appeals Committee
Qualified Employer's Insurance Carrier or Qualified Employer's Designation as Self-Insured	**COMMISSION FILE NO.**

REQUEST FOR REVIEW OF ADVERSE BENEFIT DETERMINATION

Pursuant to 85A O.S., §211, the Claimant respectfully requests the Workers' Compensation Commission to review an adverse benefit determination upheld by the above named appeals committee. In support of this application, the Claimant states as follows:

1. This request is filed with the Workers' Compensation Commission within one (1) year of the Claimant's receipt of the notice that the adverse benefit determination, or part thereof, was upheld by the appeals committee.
2. A true and correct copy of the adverse benefit determination being appealed to the Commission en banc is attached.
3. Following are the specific issues in the adverse benefit determination to be reviewed. General allegations of error do not suffice. *(Attach additional pages if needed.)* _____
_____
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_____

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.

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

Signed this _____ day of _____, _____.

Signature of Claimant	Print or Type Name of Attorney for Claimant, if any OBA #
Claimant's Address (Number and Street)	Signature of Attorney for Claimant
City State Zip	Claimant's Attorney's Address (Number and Street)
Claimant's Telephone Number	City State Zip
	Claimant's Attorney's Telephone Number

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Employer /Attorney for Employer
Address (Number & Street)
City State Zip Code

Revised 2-2-16