CC-FORM-10A

Send original to Workers' Compensation Commission and 1 copy to Claimant or the Claimant's Attorney of Record, if any

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OKLAHOMA 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 Respondent (Employer)
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

COMMISSION FILE NO.
Date of Injury

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.

RESPONDENT'S RESPONSE TO CLAIMANT'S CC-FORM-A APPLICATION FOR CHANGE OF PHYSICIAN

[For use ONLY if the worker is NOT subject to a Certified Workplace Medical Plan (CWMP).]

Pursuant to 85A O.S., §56(B) and in response to the Claimant's application for change of physician, the respondent presents to claimant the following list of three (3) physicians qualified to treat the claimant's injured body part or condition for which the change of physician is sought:

(1) Physician Name, Address and Telephone Number, including Area Code

_____

_____

_____

(2) Physician Name, Address and Telephone Number, including Area Code

_____

_____

_____

(3) Physician Name, Address and Telephone Number, including Area Code

_____

_____

_____

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."

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. **ANY PERSON WHO COMMITS WORKERS' COMPENSATION FRAUD, UPON CONVICTION, SHALL BE GUILTY OF A FELONY PUNISHABLE BY IMPRISONMENT, A FINE OR BOTH.**

Signed this_____day of_____,_____.

Signature of Filing Party
Address (Number & Street)
City **State** **Zip Code**
Telephone # of Filing Party
Print or type name of Attorney **OBA #**

I HEREBY CERTIFY THAT ON THIS _____ DAY OF _____, _____ A COPY OF THIS FORM WAS MAILED, POSTAGE PREPAID, TO:

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

Revised 12-18-14