

**OKLAHOMA WORKERS' COMPENSATION COMMISSION
COPY REQUEST FORM**

Rev. 7-1-22

FOR COMMISSION USE ONLY

**SUBMIT
REQUEST
FORM TO**

Oklahoma Workers' Compensation Commission
ATTENTION: Copy Requests
1915 North Stiles
Oklahoma City, OK 73105-4918

**COPIES
TO BE
RETURNED TO**

Company Name: _____
Attention: _____ Telephone: (____) _____
Address: _____
City/State/Zip: _____ Email: _____

FEE FOR FILES PULLED

PAID
EXEMPT

FOR EACH COMMISSION FILE NUMBER YOU MUST:

1. Use a Separate Copy Request Form, and
2. Complete and Sign Part I of this form, if applicable, OR if not applicable, Complete and Sign Part II of this form and Include a \$1 Search Fee.¹

INQUIRIES

Records Department . . . (405) 522-8695 or In-State Toll Free (855) 291-3612

Claimant's Name	Date of Injury	Commission File No.
<input type="checkbox"/> CC-FORM A Claimant's Application for Change of Physician	<input type="checkbox"/> ORDER Entered on ____/____/____	
<input type="checkbox"/> CC-FORM 3 Employee's First Notice of Claim for Compensation	<input type="checkbox"/> ALL ORDERS	
<input type="checkbox"/> CC-FORM 3A Claimant's First Notice of Death & Claim for Compensation	<input type="checkbox"/> ENTRIES OF APPEARANCE <input type="checkbox"/> SUBSTITUTION OF ATTORNEY <input type="checkbox"/> ATTORNEY WITHDRAWALS	
<input type="checkbox"/> CC-FORM 3B Employee's First Notice of Occupational Disease & Claim for Compensation	<input type="checkbox"/> ALL MEDICAL REPORTS	
<input type="checkbox"/> CC-FORM 3F Employee's Notice of Claim for Benefits from the Multiple Injury Trust Fund	<input type="checkbox"/> MFDR FORM 19 Provider Request for Medical Fee Dispute Resolution	
<input type="checkbox"/> CC-FORM 9 Request for Hearing <input type="checkbox"/> WITH ATTACHMENTS	<input type="checkbox"/> CC-FORM 20 Proof of Loss (Death Claim)	
<input type="checkbox"/> CC-FORM 10 Answer & Notice of Contested issues <input type="checkbox"/> WITH ATTACHMENTS	<input type="checkbox"/> ENTIRE FILE Files May Contain Duplicate Documents . . . BILLING IS FOR ALL COPIES, INCLUDING DUPLICATES	
<input type="checkbox"/> CC-FORM 13 Request for Prehearing Conference	<input type="checkbox"/> OTHER (Specify)	
<input type="checkbox"/> Settlement Agreement (Joint Petition) <input type="checkbox"/> WITH ATTACHMENTS		

PART I. STATEMENT OF EXEMPTION: By signing below, I affirm that I meet the requirements of an exemption from the written request and Search Fee requirements of Title 85A O.S. Section 120, as indicated below, and that the information sought is not requested for any non-exempt purpose; **provided, however, an employer or personnel service company claiming EXEMPTION #6 ALSO MUST COMPLETE PART II OF THIS FORM.** Please circle the number of the exemption that applies:

EXEMPTIONS

1. Requests made by a public officer or public employee in the performance of his/her duties on behalf of a governmental entity, or as may be allowed by law;
2. Requests made by an insurer, self-insured employer, third-party claims administrator, or a legal representative thereof, when necessary to process or defend a workers' compensation claim;
3. Requests made by a worker or worker's representative for the worker's claim information;
4. Disclosures made for educational or research purposes, in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim;
5. Requests made by a health care or rehabilitation provider, or legal representative thereof, when necessary to process payment for services rendered to a worker;
6. Requests made by an employer or personnel service company where the worker executes a written authorization permitting the search and designating the employer or personnel service company as the worker's representative for that purpose. (The written authorization must be submitted with this form.)

Your Signature: _____ Printed Name: _____

PART II. COMPLETE THIS IF EXEMPTION #6 (ABOVE) IS CLAIMED OR IF NONE OF THE OTHER EXEMPTIONS LISTED ABOVE APPLY:
By signing below, I declare under PENALTY OF PERJURY that the information sought is not for a purpose in violation of any state or federal law. I understand I am required by law to disclose the person for whom this search request is being made, if different from myself. This search is being made for:

(Name and address of person for whom this search is being made, **IF OTHER THAN THE UNDERSIGNED.** Please PRINT.)

Name _____ Full Address _____

Your Signature: _____ Printed Name: _____

Telephone No: (____) _____ Address: _____ City: _____ State: _____ Zip: _____

NOTE Please Return A Copy Of This Copy Request Form And Invoice With Your Check Made Payable To The Workers Compensation Commission

Invoice No. _____ Invoice Date: _____

_____ COPIES @\$1.00 per copy (85 A.O.S. § 119) = \$ _____ **Total amount due: \$** _____

POSTAGE = \$ _____

¹ NOTE: BY LAW, THE \$1 SEARCH FEE, IF APPLICABLE, MUST ACCOMPANY THE COPY REQUEST WHEN MADE.