OKLAHOMA WORKERS' COMPENSATION COMMISSION
COPY REQUEST FORM
Rev. 3-13-17

FOR COMMISSION USE ONLY

SUBMIT REQUEST FORM TO

Oklahoma Workers' Compensation Commission
ATTENTION: Copy Requests
1915 North Stiles Ste 231
Oklahoma City, OK 73105-4918

COPIES TO BE RETURNED TO

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

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.

- ☐ **CC-FORM A** Claimant's Application for Change of Physician
- ☐ **CC-FORM 3** Employee's First Notice of Claim for Compensation
- ☐ **CC-FORM 3A** Claimant's First Notice of Death & Claim for Compensation
- ☐ **CC-FORM 3B** Employee's First Notice of Occupational Disease & Claim for Compensation
- ☐ **CC-FORM 3F** Employee's Notice of Claim for Benefits from the Multiple Injury Trust Fund
- ☐ **CC-FORM 9** Request for Hearing ☐ **WITH ATTACHMENTS**
- ☐ **CC-FORM 10** Answer & Notice of Contested issues ☐ **WITH ATTACHMENTS**
- ☐ **CC-FORM 13** Request for Prehearing Conference
- ☐ **Settlement Agreement** (Joint Petition) ☐ **WITH ATTACHMENTS**

- ☐ **ORDER** Entered on _____/_____/_____
- ☐ **ALL ORDERS**
- ☐ **ENTRIES OF APPEARANCE** ☐ **SUBSTITUTION OF ATTORNEY** **ATTORNEY WITHDRAWALS**
- ☐ **ALL MEDICAL REPORTS**
- ☐ **MFDR FORM 19** Provider Request for Medical Fee Dispute Resolution
- ☐ **CC-FORM 20** Proof of Loss (Death Claim)
- ☐ **ENTIRE FILE** Files May Contain Duplicate Documents . . . BILLING IS FOR ALL COPIES, INCLUDING DUPLICATES
- ☐ **OTHER** (Specify)

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.**