OKLAHOMA WORKERS' COMPENSATION COMMISSION

1915 N. STILES AVE · OKC, OK · 73105 · (405) 522-3222 · WCC.OK.GOV

Tulsa office · 201 West 5th Street · Tulsa, Oklahoma 74103 · (918) 295-3732

Chairman Jordan K. Russell · Commissioner Megan Tilly · Commissioner Scott Biggs

Executive Director & General Counsel Lauren Hammonds Johnson

You are subscribed to Oklahoma Workers' Compensation Commission. This information has recently been updated, and is now available.

FOR IMMEDIATE RELEASE

12/5/2024

**Summary of Recently Updated WCC Forms**

**The WCC Commissioners voted to amend several Commission forms addressed at improving efficiency in the notice process as well as consistency with statutory language.**

**The first update was made to CC-Form M effective December 1, 2024. The change to the form includes updated language to issue number 8 to align with statutory language.**

CC-FORM-M

**WORKERS' COMPENSATION COMMISSION**

**REQUEST FOR APPOINTMENT OF INDEPENDENT MEDICAL EXAMINER, REHABILITATION EVALUATOR, OR MEDICAL CASE MANAGER**

| | |
|---|---|
| COMMISSION FILE NO. | Claimant's Social Security No. (LAST 5 DIGITS ONLY) XXX-X_____ |
| Full Name of Claimant (Injured Employee) | |
| Claimant's Mailing Address | |
| City / State / Zip Code | |
| Claimant's Date of Birth | Claimant's Telephone Number ( ) |
| IME Requested By: ☐ Claimant ☐ Respondent ☐ Commission ☐ Mutual Agreement | |

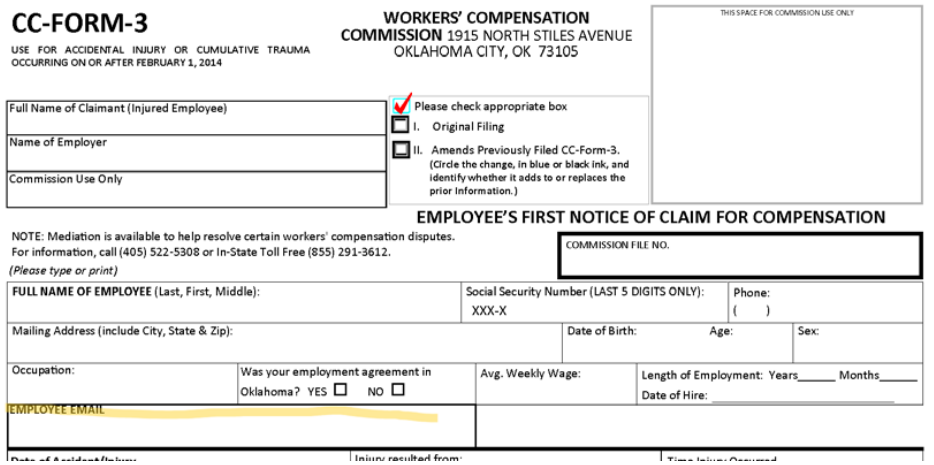
| THIS SPACE FOR COMMISSION USE ONLY: |
|---|
| NAME OF: ☐ IME Physician ☐ Rehabilitation Evaluator ☐ Medical Case Manager |
| BODY PARTS |
| Name of Respondent (Employer) |
| Name of Insurer |
| Date of Injury |
| IME Physician Selected By: ☐ Parties ☐ Commission |

**Issues:**

1. ____ Is the claimant currently temporarily totally disabled?
2. ____ Was claimant temporarily totally disabled from _____ to _____?
3. ____ Is claimant in need of additional medical treatment? Treatment is not authorized.
4. ____ Physician is requested to make specific recommendations regarding treatment.
5. ____ Does claimant need pain management?
6. ____ Does claimant need continuing medical maintenance?
7. ____ In relation to an objection to termination of temporary total disability, is the claimant in need of further medical treatment? Physician is to make specific recommendations regarding the reasonableness and necessity of further medical treatment. Treatment is not authorized unless agreed upon by the parties.
8. ____ Is the surgery recommended by the treating physician reasonably necessary in connection with the injury received?
9. ____ Is the claimant's medical treatment recommended care under the Work Loss Data Institute's *Official Disability Guidelines* (ODG) or the Physician Advisory Committee Guidelines (PACG)?

**Also updated were CC- Form 3, CC- Form 3A, CC -Form 3B, CC -Form 3C, CC -Form 3F, CC - Form 7, and CC -Form 93 effective November 1, 2024.**

**The Form 3s and Form 93 now include a field for the claimant's email address to be provided.**



**CC-FORM-3**

USE FOR ACCIDENTAL INJURY OR CUMULATIVE TRAUMA OCCURRING ON OR AFTER FEBRUARY 1, 2014

**WORKERS' COMPENSATION COMMISSION** 1915 NORTH STILES AVENUE OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Full Name of Claimant (Injured Employee)

Name of Employer

Commission Use Only

Please check appropriate box

☐ I. Original Filing

☐ II. Amends Previously Filed CC-Form-3. (Circle the change, in blue or black ink, and identify whether it adds to or replaces the prior information.)

**EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION**

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.

*(Please type or print)*

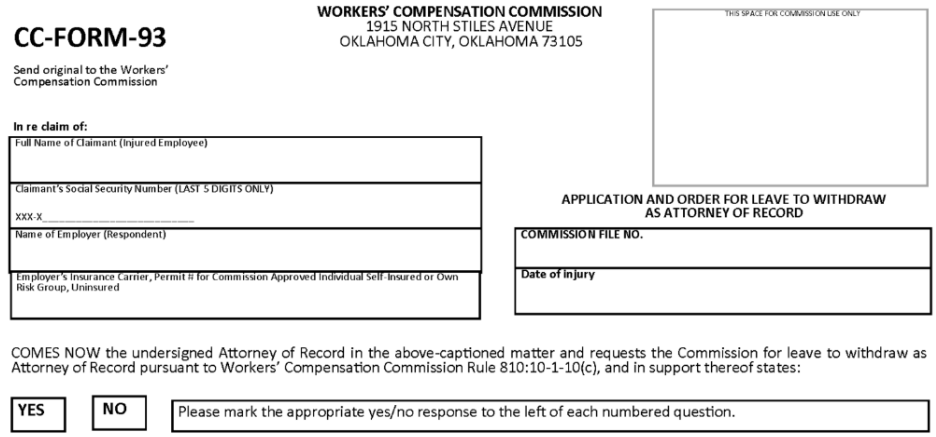
COMMISSION FILE NO.

**FULL NAME OF EMPLOYEE** (Last, First, Middle): | Social Security Number (LAST 5 DIGITS ONLY): XXX-X | Phone: ( )

Mailing Address (include City, State & Zip): | Date of Birth: | Age: | Sex:

Occupation: | Was your employment agreement in Oklahoma? YES ☐ NO ☐ | Avg. Weekly Wage: | Length of Employment: Years_____ Months_____ Date of Hire: _____

EMPLOYEE EMAIL



**CC-FORM-93**

Send original to the Workers' Compensation Commission

**WORKERS' COMPENSATION COMMISSION** 1915 NORTH STILES AVENUE OKLAHOMA CITY, OKLAHOMA 73105

THIS SPACE FOR COMMISSION USE ONLY

**In re claim of:**

Full Name of Claimant (Injured Employee)

Claimant's Social Security Number (LAST 5 DIGITS ONLY)

XXX-X_____

Name of Employer (Respondent)

Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured

**APPLICATION AND ORDER FOR LEAVE TO WITHDRAW AS ATTORNEY OF RECORD**

**COMMISSION FILE NO.**

**Date of injury**

COMES NOW the undersigned Attorney of Record in the above-captioned matter and requests the Commission for leave to withdraw as Attorney of Record pursuant to Workers' Compensation Commission Rule 810:10-1-10(c), and in support thereof states:

| YES | NO | Please mark the appropriate yes/no response to the left of each numbered question. |
|---|---|---|
| _____ | _____ | 1. The client has knowledge of this *Application To Withdraw as Attorney*. |
| _____ | _____ | 2. The client has approved the withdrawal. |
| _____ | _____ | 3. I have made a good faith effort to notify the client and the client cannot be located. |
| _____ | _____ | 4. The case is set for: ☐ Hearing ☐ PHC ☐ Mediation Date of Proceeding: _____ On the Issue(s) _____ |
| _____ | _____ | 5. The case has been heard and is pending for an Order. HEARING DATE: _____ On the Issue(s) of: _____ |
| _____ | _____ | 6. The case is pending on appeal to the : ☐ Commission En Banc ☐ Supreme Court |
| _____ | _____ | 7. An Order awarding Permanent Total Disability has been entered by the Commission. DATE OF ORDER: _____ |
| _____ | _____ | 8. An Order awarding Death Benefits has been entered by the Commission. DATE OF ORDER: _____ |

**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.**

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

**Opposing Party**

**Address (Number & Street)**

**City** **State** **Zip Code**

**Withdrawing Attorney's Client**

**Address (Number & Street)**

**City** **State** **Zip Code**

**Phone Number**

**Email**

Signed this _____ day of _____, _____

**Signature of Requesting Party**

**Address (Number & Street)**

**City** **State** **Zip Code**

**Telephone # of Requesting Party**

**Print or type name of Attorney** **OBA #**

IT IS THEREFORE ORDERED, for good cause shown, that the above signed attorney is hereby permitted to withdraw as Attorney of Record from the above captioned case.

**BY ORDER OF** _____ _____

**Administrative Law Judge** **Date of Order**

**Revised 11-1-2024**

**The CC-Form 7 is a redesigned Permitting Services Division form to ensure the Commission has on file the most current contact information for a designated service agent.**

**WORKERS' COMPENSATION COMMISSION**
**1915 NORTH STILES AVE**
**OKLAHOMA CITY, OK 73105**
permittingservices@wcc.ok.gov
**405-522-8680**

**PLEASE CHECK THE APPROPRIATE BOX**

- ☐ **Insurance Carrier**
- ☐ **Individual Own Risk Employer**
- ☐ **Group Self-Insurance Association**

# CC-FORM-7
## DESIGNATION OF SERVICE AGENT
## (FOR CLAIMS NOTIFICATION PURPOSES)

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

Insurance carriers, individual own-risk employers and group self-insurance associations must designate a single agent for claims notifications by filing this Designation of Service Agent form with the Commission.

Once a claim for compensation (CC-Form-3, CC-Form-3A or CC-Form-3B) is filed, the Commission will send all notices and correspondence to the Designated Service Agent, until an Entry of Appearance or a Notice of Substitution of Attorney is filed as provided in Commission Rules 810:10-1-10 or -11.

**An updated Form 7 is required annually and anytime a change of Designated Service Agent is made.**
If this Designated Service Agent designation applies to the entity's subsidiaries, attach a list of the applicable subsidiaries and/or affiliates, including addresses.

**DESIGNATED SERVICE AGENT INFORMATION FOR CLAIMS NOTIFICATION PURPOSES:**

Designated Service Agent Name _____ Designated Service Agent Phone Number _____

Name of Contact Person (if service agent is a business) _____ Service Agent Email (**Required**) _____

Mailing Address _____ City _____ State _____ Zip _____

Entity Name _____ Entity Phone Number _____

Name of contact person (**Non Claims Communications**) _____ Contact Email (**Required**) _____

Mailing Address _____ City _____ State _____ Zip _____

**By submitting this Form, I agree that claims notifications shall be sent to the Designated Service Agent listed above**

**Signature of Entity Representative** _____ **Printed Name of Entity Representative** _____

**Date Signed** _____ **Title of Entity Representative** _____

**EMAIL COMPLETED FORM TO:**
permittingservices@wcc.ok.gov

Revised 10/14/24

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