FORM 2

Send original to
Workers' Compensation Court and 1 copy to
Insurance Carrier
Please type or print. Enter all dates in MM/DD/YY format.

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

EMPLOYER'S FIRST NOTICE OF INJURY

Full Name of Employee - LAST, FIRST, MIDDLE			
Complete Address	City	State	Zip
Telephone Number	Social Security Number		
Date of Birth	Sex	Length of Employment Years _____ Months _____	
Average Weekly Wage	Occupation (job description)	Was employment agreement made in Oklahoma? YES ☐ NO ☐	

NOTE: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers' Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

Date of accident or last exposure	Time of accident or exposure _____ o'clock AM ☐ PM ☐	Date Employer Notified	Time workday began _____ o'clock AM ☐ PM ☐
Last date employee worked	Has employee returned to work? YES ☐ NO ☐ If yes, on what date _____	Did the employee die? YES ☐ NO ☐ If yes, on what date _____	
OSHA Log Case #	Place of Accident or Occurrence City:	County:	State:
Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐	Does employee participate in a certified workplace medical plan: YES ☐ NO ☐ If yes, name of CWMP: _____		
Nature of Injury or Illness			
Describe activities when injury occurred with details of how event occurred. Include object or substance which directly injured the employee.			
Identify part(s) of body involved in injury or illness			
Full Name and address of Treating Physician (please be complete)			

Employer's Insurance Carrier or Own Risk Group		Policy/Self-Insured Number	
Name	Phone	Policy Period—from _____ to _____	
Address	City	State	Zip
Employer's Name and Complete Address			
Name	Federal ID#	Phone #	
Address	City	State	Zip
Type of business (Example: manufacturing, food service, construction)		SIC Number	
Type of Ownership: Private ☐	State Government ☐	County Government ☐	Local Government ☐

Upon filing this Notice of Injury, permission is given to the Administrator of the Workers' Compensation Court, the Insurance Commissioner, the Attorney General, a District Attorney or their designees to examine all records relating to the notice, any matter contained in the notice, and any matter relating to the notice.

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

I hereby declare under penalty of perjury that I have examined this notice, and 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.

Signed this _____ day _____ , _____

Prepared by _____

Title _____

I hereby certify that this Form 2 was sent to the Workers' Compensation Court and a copy thereof to the insurer on the date described below:

_____ , _____

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

A Form 2 must be sent to the Workers' Compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise.

08/02