

# CC-FORM-2

Applicable to Injuries /Deaths Occurring On or After 2/1/14

**WORKERS' COMPENSATION COMMISSION**  
1915 NORTH STILES AVENUE STE 231  
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

Send original to Workers' Compensation Commission and  
1 copy to Insurance Carrier

*Please type or print. Enter all dates in MM/DD/YY format.*

## EMPLOYER'S FIRST NOTICE OF INJURY

|                                             |                              |                                                                     |                                                                                                        |
|---------------------------------------------|------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Full Name of Employee - LAST, FIRST, MIDDLE |                              | Employee Email Address                                              |                                                                                                        |
| Complete Address                            |                              | City                                                                | State Zip                                                                                              |
| Telephone Number                            |                              | Employee's Social Security Number (LAST 5 DIGITS ONLY)<br>XXX-X     |                                                                                                        |
| Date of Birth                               | Sex                          | Length of Employment: Years ____ Months ____<br>Date of Hire: _____ |                                                                                                        |
| Average Weekly Wage                         | Occupation (job description) |                                                                     | Was employment agreement made in Oklahoma?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |

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.

|                                                                                                                                                         |                                                                                                                         |                                                                                                                                                          |                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| Date of accident or last exposure                                                                                                                       | Time of accident or exposure<br>o'clock AM <input type="checkbox"/> PM <input type="checkbox"/>                         | Date Employer Notified                                                                                                                                   | Time workday began<br>o'clock AM <input type="checkbox"/> PM <input type="checkbox"/> |
| Last date employee worked                                                                                                                               | Has employee returned to work?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date ? _____ | Did the employee die?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, on what date ? _____                                           |                                                                                       |
| OSHA Log Case #                                                                                                                                         | Place of Accident or Occurrence<br>City: _____ County: _____ State: _____                                               |                                                                                                                                                          |                                                                                       |
| Injury Resulted from: Single Incident <input type="checkbox"/> Cumulative Trauma <input type="checkbox"/> Occupational Disease <input type="checkbox"/> |                                                                                                                         |                                                                                                                                                          |                                                                                       |
| Nature of Injury or Illness                                                                                                                             |                                                                                                                         | Does employee participate in a certified workplace medical plan: YES <input type="checkbox"/> NO <input type="checkbox"/><br>If yes, name of CWMP: _____ |                                                                                       |
| 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)                                                                                        |                                                                                                                         |                                                                                                                                                          |                                                                                       |
| <hr/>                                                                                                                                                   |                                                                                                                         |                                                                                                                                                          |                                                                                       |
| 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                                                                                                                    |                                                                                                                         | Federal ID# _____ Phone # _____ State _____ Zip _____                                                                                                    |                                                                                       |
| Type of business (Example: manufacturing, food service, construction)                                                                                   |                                                                                                                         |                                                                                                                                                          | NAICS Number _____                                                                    |
| Type of Ownership:                                                                                                                                      | Private <input type="checkbox"/>                                                                                        | State Government <input type="checkbox"/>                                                                                                                | County Government <input type="checkbox"/> Local Government <input type="checkbox"/>  |

**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."

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

The undersigned hereby declares under PENALTY OF PERJURY that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this CC-Form 2 was sent to the Workers' Compensation Commission and a copy thereof to the employer's insurer on the date noted below:

Signed \_\_\_\_\_  
Signature of Preparer

By \_\_\_\_\_  
Name and Title of Preparer (Please Print)

Telephone Number \_\_\_\_\_  
Area Code and Number

Date \_\_\_\_\_

**A CC-Form 2 must be sent to the Workers' Compensation Commission and to the employer's workers' compensation insurance carrier within 10 days after the date of receipt of notice or knowledge of death or injury that results in the loss of time beyond the shift or requires medical attention away from the work site.**

**PROVIDING THIS FORM TO THE COMMISSION IS NOT EVIDENCE OF ANY FACT STATED IN THE REPORT IN ANY PROCEEDING WITH RESPECT TO THE INJURY OR DEATH ON ACCOUNT OF WHICH THE REPORT IS MADE.**