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

THIS SPACE FOR COURT USE ONLY

Full Name of Employee - LAST, FIRST, MIDDLE			Employee Email Address
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: Mediation is available to address certain workers' compensation disputes.
For information, call (405) 522-8760 or In-State Toll Free (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 ☐ Occupational Disease ☐

Nature of Injury or Illness	Does employee participate in a certified workplace medical plan: YES ☐ NO ☐ 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)

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)		NAICS 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 within seven (7) days 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.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

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 Form 2 was sent to the Workers' Compensation Court 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 Form 2 must be filed with the Workers' Compensation Court and sent to the Employer's workers' compensation insurance carrier within 10 days of notice 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. Form 2s filed with the Workers' Compensation Court are confidential and not subject to public disclosure except as authorized by law.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY OR THAT THE EMPLOYEE HAS PROVIDED PROPER NOTICE OF INJURY.