Employees Notice of Injury

3420 N. Santa Fe **PARTNERS HUMAN RESOURCES** Phone Fax
Oklahoma City, OK 73118 (405) 917-1020 (405) 972-4777

Name (last, First, Middle)	Social Security Number	Sex	Phone ( )
Street Address	City	OK	Zip code
Occupation	State of Employee Agreement	Average Weekly Wage	Length of Employment Months_____Years_____

Date of Accident	Time ___AM ___PM	Place of Injury (City, County, State)

Body area injured	Describe in detail how the injury occurred. Include any contributing factors (Rain, ice, snow,darkness,etc.)

Treating Physician (full name)	Address	City	State	Zip
Name of Co-employer		Job site location		

Were you a previously impaired person due to a prior workers' compensation injury or obvious pre-existing disability caused by a/an accident, disease, birth defect or military injury, which may impact the treatment of this injury? _____yes _____no If "yes" please describe below:

Date	Description	Physician

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 a/an change in material fact, or the amount of income he/she is receiving, or any change in his/her employment status, occurring during the period of such benefits.
I declare under penalty of perjury that I have examined this notice and claim, 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.

Upon filing this Notice of Accidental Injury and Claim for compensation, permission is given to the Administrator of the Workers' Compensation Court, The Insurance Commissioner, The Attorney General, a District Attorney, the Insurance adjuster or their designees to examine all records relating to the notice. The permission granted to the above named individuals or their designees authorizes them access to medical records, including waiver of any privilege granted by law concerning communication made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination.

The information authorization for release may include information, which may be considered a communicable venereal disease, which may include but not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome.

Signed this _____day of _____,_____

_____ _____
Employee Signature Print Employee Name

This form constitutes a medical authorization for release of medical records. Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.