FORM 10

Send original to
Court of Existing Claims and 1 copy to
Claimant or the Claimant's Attorney of Record

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

In re claim of:

Full Name of Injured Employee (Claimant)
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

ANSWER AND PRETRIAL STIPULATION OFFERED BY RESPONDENT

WCC FILE NO.
Date of Injury

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (918) 581-2714.

YES	NO	(Please Type or Print)
_____	_____	1. Was claimant at the time of the alleged injury, an employee of the above named respondent?
_____	_____	2. Was claimant covered by the Workers' Compensation Code?
_____	_____	3. Did claimant sustain an accidental injury or suffer an occupational disease arising out of and in the course of the employment?
_____	_____	4. Has claimant filed a Form 3 within the statutory period of time?
_____	_____	5. Did respondent, at the time of the alleged injury, have an own-risk permit or a compensation insurance policy with the carrier named in the caption above?
_____	_____	6. Did claimant timely notify respondent of the injury?
_____	_____	7. Has claimant been provided medical treatment?
_____	_____	8. Has respondent commenced payment of temporary total disability payments to claimant? Temporary total disability has been paid to claimant from _____ to _____ for a total of _____ weeks in the total sum of $_____ .
_____	_____	9. Has respondent selected a treating physician? The treating physician is _____ (name of treating physician).

(ALL DEPOSITIONS OF MEDICAL EXPERTS SHALL BE COMPLETED PRIOR TO TRIAL)

_____ _____ 10. Is rate an issue? Claimant's compensation rate: TTD _____ PPD/PPI _____.

11. State all affirmative defenses: _____
_____

12. List the names of all witnesses who may be called by respondent at trial: _____
_____

13. List all exhibits to be introduced at trial: _____
_____

14. Respondent hereby certifies that a copy of the medical report written by Dr. _____ and dated _____, was mailed, together with a copy of this motion to Opposing party/Counsel.

(LIST ON A SEPARATE SHEET, ADDITIONAL WITNESSES, EXHIBITS AND MEDICAL EVIDENCE)

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.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Signed this _____day of_____,_____.

Opposing Party
Address (Number & Street)
City **State** **Zip Code**

Signature of Filing Party
Address (Number & Street)
City **State** **Zip Code**
Telephone # of Filing Party
Print or type Name of Attorney **OBA #**

Rev. 06/24/2015