

# FORM 3B

Send original and 4 copies to:  
Court of Existing Claims

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

THIS SPACE FOR COURT USE ONLY

Name of Claimant (Injured Employee)
Name of Employer
Court use only

Please check appropriate box

I. Original Filing

II. Amends Previously Filed Form 3B (Must clearly state whether amendment is in addition to, or substitute for, prior information.)

### EMPLOYEE'S FIRST NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION

WCC FILE NO.

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

(Please type or print)

EMPLOYEE NAME (Last, First, Middle):		Social Security #:	Phone: ( )
Mailing Address (include City, State & Zip):		Date of Birth:	Age: Sex:
Occupation:	Was your employment agreement in Oklahoma? YES <input type="checkbox"/> NO <input type="checkbox"/>	Avg. Weekly Wage:	Length of Employment months _____ years _____
Date of last exposure to hazard which caused disease:	Date of first distinct manifestation:	Place of Injury: City/County/State	
Nature of Disease (example: Reduced breathing capacity or loss of vision)		Body Part(s) Injured:	
Describe how you were exposed to the disease with details of how event occurred. Include object or substance which directly injured you:			
Have you filed a claim for Social Security Disability Insurance Benefits? YES <input type="checkbox"/> NO <input type="checkbox"/>		Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of Occupational Disease and Claim for Compensation? YES <input type="checkbox"/> NO <input type="checkbox"/>	

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? \_\_\_\_\_ If "YES", you may be entitled to benefits for combined disabilities from the Multiple Injury Trust Fund. A claim for benefits for combined disabilities against the Multiple Injury Trust Fund may be commenced by filing a "Form 3F" with the Court of Existing Claims.

Employer:	Employer's FEI # (Federal ID Number):	Telephone:
Complete Mailing Address:	City:	State: Zip:
Complete Street Address (if different from above):	City:	State: Zip:

**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.**

Name of claimant's attorney if represented:	
Type or Print Name of Attorney:	OBA#
Mailing Address:	
City	State Zip
Telephone #: ( )	

Upon filing this *Notice of Occupational Disease and Claim For Compensation*, permission is given to the Administrator of the Court of Existing Claims, the Insurance Commissioner, the Attorney General, a district attorney or their designees to examine all records relating to the notice. The permission granted to the above named persons authorizes them access to medical records pursuant to 76 O.S., § 19, including waiver of any privilege granted by law concerning communications made to a physician or health care provider or knowledge obtained by such physician or health care provider by personal examination. This form is not intended for use as a medical authorization. Nothing shall be construed to waive, limit or impair any evidentiary privilege recognized by law.

I declare under penalty of perjury that I have examined this *Notice of Occupational Disease and Claim for Compensation*, and all statements contained herein are true, correct and complete, to the best of my knowledge and belief.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_