FORM 4

SEND COPIES TO
1—Injured Worker
1—Employer
1—Employer's Insurer

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

WCC FILE NO.
(Must be filled out)

TREATING PHYSICIAN'S REPORT AND NOTICE OF TREATMENT

(Please type or print)

1. HISTORY OF ACCIDENT: Date and Time of Accident		Occupation or job of employee
State, in the employee's own words, how the accident occurred.		
Were the employee's injuries causally connected to the above described accident?		
2. MEDICAL HISTORY	Age	Date of birth
State the objective complaints of the employee.		
State whether previous sickness or injury contributed to the employee's present condition.		
Was the employee hospitalized?	Other significant medical history of the employee.	
Describe the medical treatment rendered to date.		
List all other treating or consulting physicians.		Were medical records reviewed?
3. <u>CLINICAL EVALUATION</u>: Describe your examination and all diagnostic tests performed.		
State your findings and diagnoses.		
Describe the medical treatment you recommend for the future.		
4. <u>EVALUATION OF TEMPORARY TOTAL DISABILITY</u>: Date of employee's first treatment by you.		
State the date you released the employee as able to return to work.		
Has the employee been totally unable to return to work for any period?		
Employee was temporarily totally disabled from:		
Is the employee's inability to work the result of the above described accident?		

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:

☐ Employee	☐ Employer	☐ Insurance Carrier
Address (Number and Street)		
City	State	Zip Code

Signed this _____ day of _____, _____

Type or Print Name of Treating Physician
Signature of Treating Physician
Address
City State Zip Code