

FORM 2

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OKLAHOMA 73105-4918

EMPLOYER'S FIRST NOTICE OF INJURY

SEND COPIES TO:
1-Workers' Compensation Court
1-Insurance Carrier

THIS SPACE FOR COURT USE ONLY

Please type or print. Enter all dates in MM/DD/YY format.

Full Name of Claimant (Injured Worker), LAST, FIRST, MIDDLE
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: A voluntary Mediation Program to address certain workers' compensation disputes is available through the Workers Compensation Court. For information, call (405) 522-8760 or (800) 522-8210.

Date of accident or last exposure Time of accident or exposure Date Employer notified Time workday began
Last date employee worked Has employee returned to work Did employee die

Place of Accident or Occurrence City: County: State

Injury Resulted From: Single Incident Cumulative Trauma

Nature of Injury or Illness

Describe activities when injury occurred with details of how event occurred. Include object or substance when 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 Name: GuideOne Insurance Group
Address: 300 W. Arbrook, Ste A, Arlington, TX 76014
Fax: 800-233-2698 Phone: 800-441-1554 Attn: Becky Rose
Policy/Self-Insured Number: 01199240 Policy Period - From: 06-01-04 to 06-01-05

Employer's Name and Complete Address Name: The University of Tulsa
Address: 600 S. College Attn: Ms. Jannette Assaly
Federal ID #: 73-0579298 City: Tulsa State: OK Zip: 74104
Phone: 918-631-2373

Type of business (Example: manufacturing, food service, construction) Private University
Type of ownership: Private X State Gov't County Gov't Local Gov't SIC Number

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 of 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 promptly report in writing to the employer or insurance carrier any change in a material fact or the amount of income he is receiving or any change in his employment status, occurring during the period of receipt of such benefits.

I hereby declare under penalty of perjury that I have examined this notice, 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.

Signed this \_\_\_\_\_ day of \_\_\_\_\_ 2005
Prepared by \_\_\_\_\_
Title \_\_\_\_\_

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO THE WORKERS' COMPENSATION COURT ON THE DATE DESCRIBED BELOW:

SUBMISSION OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

A Form 2 must be sent to the Workers' compensation Court and to the Employer's Workers' Compensation Insurance Carrier within 10 days, or a reasonable time thereafter, of learning that an employee has suffered an accidental injury requiring medical attention away from the work site or resulting in lost time beyond the shift.