Oklahoma

FORM 2

Send original to
Workers' Compensation Court and 1 copy to
Insurance Carrier
Please type or print. Enter all dates in MM/DD/YY format.

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

EMPLOYER'S FIRST NOTICE OF INJURY

THIS SPACE FOR COURT USE ONLY

Full Name of Employee - LAST, FIRST, MIDDLE

Employee Email Address

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: Mediation is available to address certain workers' compensation disputes.
For information, call (405) 522-8760 or In-State Toll Free (800) 522-8210.

Date of accident or last exposure | Time of accident or exposure o'clock AM ☐ PM ☐ | Date Employer Notified | Time workday began o'clock AM ☐ PM ☐

Last date employee worked | Has employee returned to work? YES ☐ NO ☐ If yes, on what date | Did the employee die? YES ☐ NO ☐ If yes, on what date

OSHA Log Case # | Place of Accident or Occurrence City: County: State:

Injury Resulted from: Single Incident ☐ Cumulative Trauma ☐ Occupational Disease ☐

Nature of Injury or Illness | Does employee participate in a certified workplace medical plan: YES ☐ NO ☐ If yes, name of CWMP:

Describe activities when injury occurred with details of how event occurred. Include object or substance which 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 ☐ Federated Mutual Insurance Company
☒ Federated Service Insurance Company

Phone (800) 533-0472

Policy/Self-Insured Number 339-495-4

Policy Period—from 4/13 to 4/14

Address PO Box 486 Owatonna, MN 55060-0486

Fax 866-636-8660

Employer's Name and Complete Address

Name Nebraskaland Tire Inc. dba Guymon Tire

Federal ID# 470561185

Phone # 316 522 5114

Address 2904 S Spruce

City Wichita

State KS

Zip 67216

Type of business (Example: manufacturing, food service, construction) tires

NAICS Number 441320

Type of Ownership: Private ☒ State Government ☐ County Government ☐ Local Government ☐

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 or 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 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.

The undersigned hereby declares under penalty of perjury that they have examined this notice and all statements contained herein are true, correct and complete, to the best of their knowledge. The undersigned certifies this Form 2 was sent to the Workers' Compensation Court and a copy thereof to the employer's insurer on the date noted below:

Signed ______________________
Signature of Preparer

By ______________________
Name and Title of Preparer (Please Print)

Telephone Number ______________________
Area Code and Number

Date ______________________

A Form 2 must be filed with the Workers' Compensation Court and sent to the Employer's workers' compensation insurance carrier within 10 days of notice that an employee has suffered an accidental injury which results in lost time beyond the shift, or requires medical attention away from the work site, fatal or otherwise. Form 2s filed with the Workers' Compensation Court are confidential and not subject to public disclosure except as authorized by law.

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY OR THAT THE EMPLOYEE HAS PROVIDED PROPER NOTICE OF INJURY.