FORM 14

Send Original and 5 copies to
Workers' Compensation Court

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

THIS SPACE FOR COURT USE ONLY

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

(Please type or Print ALL information legibly in ink)

AGREEMENT BETWEEN EMPLOYER AND EMPLOYEE AS TO FACT WITH RELATION TO AN INJURY AND PAYMENT OF COMPENSATION

FILE NO.
Date of Accident

We, the above named parties, have reached an agreement in regard to the facts with relation to an injury sustained by said employee and payment of compensation therefor, and submit the following:

1. That said injury was sustained on _________________________, ______, at (time) _________; that claimant's injury arose out of and in the course of employment with said employer; that claimant timely notified employer; that claimant's employment was covered by the Workers' Compensation Act and that this court has jurisdiction in the matter.

2. That the nature of said injury was _________________________________, resulting in claimant's **Temporary Total Disability** from _________________, ______ to _________________, ______ or for a period of ___________ weeks, for which claimant received $________________ in compensation, computed at ______________ per week, based upon claimant's hourly wage of ___________.

3. That as a result of said injury, claimant sustained **Permanent Disability** (______%) to ___________________________________, for which claimant is entitled to $_____________________ per week for ___________ weeks, beginning on _________________ and that employer has furnished all reasonable and necessary medical services in the treatment of said injury.

4. The sum of $___________________ shall be deducted from this award and paid to the claimant's attorney as a fair and reasonable fee. Claimant ACCEPTS the fee amount and payment method, and WAIVES THE RIGHT TO A FEE HEARING. [Claimant's Initials] Claimant REJECTS the fee amount and payment method and REQUESTS A FEE HEARING. [Claimant's Initials]

The foregoing agreement is herewith submitted for the order, decision or award of this court, under the provisions of the Workers' Compensation Act of the State of Oklahoma. It is a condition, however, of this agreement that in the event a change in condition occurs or arises, that the same shall not be final, but may be reopened and reviewed as provided by law. We, the undersigned, declare under penalty of perjury that we have examined this agreement and all statements contained herein, and to the best of our knowledge and belief, they are true, correct and complete. Any person who commits worker's compensation fraud, upon conviction, shall be guilty of a felony.

Signed this _________ day of ________________________, _________.

X ____
Signature of Claimant

____
Address of Claimant

____
Name of Attorney for Claimant OBA #

____
Signature of Attorney for Claimant

Signed this _________ day of ________________________, _________.

____
Employer or Respondent

____
Name of Insurance Carrier or Own Risk Group

____
Type or Print Name of Attorney for Respondent/Insurer OBA #

X ____
Signature of Attorney for Respondent/Insurer

____
Mail Approved Copy To

Order Approving Form 14 Agreement

Now on this _______________ day of __________________, __________, the Workers' Compensation Court having reviewed the evidence submitted herein by all parties, and being well and fully advised in the premises, finds that the above Form 14 Agreement incorporated herein and made a part hereof by reference should be and is hereby approved.

IT IS THEREFORE ORDERED, that the respondent or insurance carrier pay to the claimant the sum of $_______________, same being for Permanent Disability (___________%) to ____; to pay authorized, reasonable and necessary medical expenses incurred by claimant by reason of said injury of ______________, _____________ and within 20 days of this Order, respondent or insurance carrier shall comply herewith.

IT IS THEREFORE ORDERED, that the respondent, if uninsured, shall pay a Multiple Injury Trust Fund assessment in the sum of $_________________, representing 5% of the total compensation paid herein for permanent disability and death benefits.

IT IS FURTHER ORDERED, that respondent or insurance carrier shall pay court costs in the amount of $140.00 for each case, unless the court cost was previously paid, the Special Occupational Health and Safety Tax in the sum of $________________, representing three-fourths of one percent of the entire award, excluding medical payments and Temporary Total Disability; and the respondent, if own risk, shall also pay the sum of $_____________ representing 2% of the total compensation paid herein for Permanent Disability and Death Benefits to the Worker's Compensation Administration Fund and the sum of $_____________ representing 1% of said award to the appropriate Self-Insured Guaranty Fund, if applicable by law.

A copy hereof was mailed by United Stated regular mail on this file-stamped date to all attorneys of record and to unrepresented parties.

BY ORDER OF ____