FORM 4A

SEND COPIES TO:
1- Employee/Claimant
1 - All Other Parties of Record

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

THIS SPACE FOR COURT USE ONLY

In re claim of:

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

TREATING PHYSICIAN'S PROGRESS REPORT

FILE NO.
Date of Injury

(Please type or print)

DATE

PROGRESS REPORT:

Is this employee temporarily totally disabled? ☐ NO ☐ YES

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/Counsel		
Address (Number & Street)		
City	State	Zip Code

Employer/Counsel		
Address (Number & Street)		
City	State	Zip Code

Signature of Physician		
Address (Number & Street)		
City	State	Zip Code
Telephone Number of Treating Physician		
Print or type name of Treating Physician		