

|                                       |   |                    |
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| Rev. 3/10                             | STATE OF OKLAHOMA WORKERS' COMPENSATION COURT<br><b>COPY REQUEST FORM</b>   | FOR COURT USE ONLY |
| <b>SUBMIT<br/>REQUEST<br/>FORM TO</b> | OKLAHOMA WORKERS' COMPENSATION COURT<br>ATTENTION: COPY REQUESTS<br>1915 NORTH STILES<br>OKLAHOMA CITY, OK 73105-4918 |                    |

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| <b>COPIES<br/>TO BE<br/>RETURNED<br/>TO</b> | COMPANY NAME: _____<br>ATTENTION: _____ TELEPHONE: (____) _____<br>ADDRESS: _____<br>CITY/STATE/ZIP: _____ | FEE FOR FILES PULLED<br>PAID <input type="checkbox"/><br>EXEMPT <input type="checkbox"/> |
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| <b>FOR EACH CASE NUMBER YOU MUST</b><br>1. USE A SEPARATE COPY REQUEST FORM, AND<br>2. THE CLAIM(S) FOR WHICH COPIES FROM THE FILE ARE BEING REQUESTED, MUST INCLUDE A "PRIOR CLAIMS" REPORT PRODUCED BY THE RECORDS DEPT. OF THE COURT, THE SIGNED EXEMPTION STATEMENT, OR IF NON-EXEMPT INCLUDE THE \$1 FEE PER CLAIM TO BE COPIED. | <b>INQUIRIES</b><br>GENERAL INQUIRIES . . . RECORDS DEPT. (405) 522-8640<br>RECORDS MANAGEMENT DEPT. SUPERVISOR . . . RENEA MARTIN (405) 522-8659 |
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| <b>CLAIMANT'S NAME</b>  | <b>DATE OF INJURY</b>  | <b>WORKERS' COMPENSATION COURT FILE NO.</b> |
| <input type="checkbox"/> <b>FORM A</b> CHANGE OF PHYSICIAN  | <input type="checkbox"/> <b>Settlement Agreement (F14, F26, F1X, JP)</b>   |   |
| <input type="checkbox"/> <b>FORM 3</b> Employee's First Notice of Accidental Injury & Claim for Compensation                                    | <input type="checkbox"/> <b>ORDER</b> Entered On ____ / ____ / ____ <input type="checkbox"/> <b>ALL ORDERS</b>   |   |
| <input type="checkbox"/> <b>FORM 3A</b> Claimant's First Notice of Death & Claim for Compensation   | <input type="checkbox"/> <b>ENTRIES OF APPEARANCE</b> <input type="checkbox"/> <b>SUBSTITUTION OF ATTORNEY</b><br><input type="checkbox"/> <b>ATTORNEY WITHDRAWALS</b> |   |
| <input type="checkbox"/> <b>FORM 3B</b> Employee's First Notice of Occupational Disease & Claim for Compensation                                | <input type="checkbox"/> <b>MEDICAL REPORTS OF DR.</b> _____   |   |
| <input type="checkbox"/> <b>FORM 3E</b> Employee's Claim for Benefits for Combined Disabilities Against Last Employer                           | <input type="checkbox"/> <b>ALL MEDICAL REPORTS</b>  |   |
| <input type="checkbox"/> <b>FORM 3F</b> Employee's Claim for Benefits from the Multiple Injury Trust Fund                                       | <input type="checkbox"/> <b>FORM 19</b> Request for Payment of Charges for Medical or Rehabilitative Service Notice of Appeal of Administrative Order                  |   |
| <input type="checkbox"/> <b>FORM 9</b> Motion to Set for Trial<br><input type="checkbox"/> <b>WITH ATTACHMENTS</b>                              | <input type="checkbox"/> <b>FORM 20</b> Proof of Loss in Death Claim   |   |
| <input type="checkbox"/> <b>FORM 10</b> Answer & Pretrial Stipulation Offered by Respondent<br><input type="checkbox"/> <b>WITH ATTACHMENTS</b> | <input type="checkbox"/> <b>ENTIRE FILE</b> Files May Contain Duplicate Documents . . . BILLING IS FOR ALL COPIES, INCLUDING DUPLICATES                                |   |
| <input type="checkbox"/> <b>FORM 13</b> Request for Prehearing Conference   | <b>3. OTHER (Specify)</b>  |   |

**STATEMENT OF EXEMPTION**

By signing below, the undersigned represents and acknowledges as follows: that the undersigned meets the requirements of an exemption defined in Title 85 O.S. Section 110, as indicated below; that the information sought will not be used for any unlawful or non-exempt purpose; that any misuse of the information sought may subject the undersigned to legal sanctions. Please circle the number of the exemption that applies:

**EXEMPTIONS:**

1. Requests made by a public officer/employee in the performance of governmental duties, or as allowed by law;
2. Requests made by an insurer, self-insured employer, third-party claims administrator, or a legal representative thereof, when necessary to process or defend a workers' compensation claim;
3. Requests made by a worker or worker's representative for the worker's claim information;
4. Disclosures made for educational or research purposes, in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim;
5. Requests made by a health care or rehabilitation provider, or legal representative thereof, when necessary to process payment for services rendered to a worker;
6. Requests made by an employer or personnel service company where the worker executes written authorization for the search and designates the employer or personnel service company as the workers' representative for that purpose.

Your Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**FOR COURT USE ONLY - DO NOT WRITE BELOW THIS LINE**

**NOTE → → TO INSURE PROPER CREDIT TO YOUR ACCOUNT . .  
PLEASE SEND COPY OF ENTIRE INVOICE WITH YOUR CHECK**

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| INVOICE NO: _____<br><small>(NOTE: ALL APPLICABLE SEARCH FEES MUST ACCOMPANY REQUESTS AND WILL NOT BE BILLED)</small><br>_____ TOTAL COPIES (1 <sup>st</sup> COPY \$1.00/ADDITIONAL COPIES 50¢ EACH) ..... \$ _____<br><small><sup>1</sup>PURSUANT TO 85 O. S. §95</small> | INVOICE<br>DATE: ____ / ____ / ____<br><br><b>TERM S :</b><br><b>DUE IN 30 DAYS</b> |
| POSTAGE ..... \$ _____   |   |
| <b>TOTAL INVOICE AMOUNT</b> ..... \$ _____   |   |