FORM 100

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Court of Existing Claims

COURT OF EXISTING CLAIMS
1915 NORTH STILES, STE 127
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

In re claim of:

Full Name of Claimant (Injured Employee)
Claimant's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-_____
Name of Employer (Respondent)
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-insured or Own Risk Group

CLAIMANT'S APPLICATION AND ORDER FOR DISMISSAL

WCC FILE NO.
Date of Injury

The claimant moves to DISMISS the above referenced claim pursuant to 85 O.S. § 319, and in support thereof, states:

YES	NO	Please mark the appropriate YES/NO response to the left of each numbered question.
_____	_____	1. The filing fee of $140.00 has been paid and a receipt evidencing payment is attached to this application. *(Payment of the fee is required to effect the dismissal. 85 O.S., §319.)*
_____	_____	2. The claimant is represented by counsel.
_____	_____	*3.* A permanent total disability order, permanent partial disability/permanent partial impairment order, or Settlement Agreement has been entered. *(An order of dismissal is permissible at any time before final submission of the case to the Court for decision. 85 O.S., §319.)*
_____	_____	4. This request is for a dismissal with prejudice. *(Prior to entering an order for dismissal with prejudice, the Court may require an evidentiary hearing.)*

Note: If a workers' compensation claim is timely filed and then dismissed without prejudice, the claim may be refiled within one (1) year from the date the Order of Dismissal Without Prejudice is filed, even if the limitations period has run.

I declare under penalty of perjury that I have examined all statements contained herein and they are true, correct and complete, to the best of my knowledge and belief. 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:

Opposing Party(ies)
Address (Number & Street)
City **State** **Zip Code**

Claimant
Address (Number & Street)
City **State** **Zip Code**
Telephone # of Claimant

Signed this _____ day of _____, _____

Signature of Claimant
Print or type name of Attorney for Claimant **OBA #**
Signature of Attorney of Claimant

IT IS THEREFORE ORDERED, for good cause shown, that the above captioned claim is dismissed :
_____ *With Prejudice* _____ *Without Prejudice*

The filing of this order does not adjudicate the rights of any health care provider that has provided reasonable and necessary medical care to the claimant for a work related injury.

BY ORDER OF _____ _____
Date of Order

Rev. 06/24/2015