FORM 10A

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

THIS SPACE FOR COURT USE ONLY

Send original to
Court of Existing Claims and 1 copy to
Claimant or the Claimant's Attorney of
Record

In re claim of:

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

WCC FILE NO.
Date of Injury

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (918) 581-2714.

RESPONDENT'S RESPONSE TO CLAIMANT'S FORM-A APPLICATION FOR CHANGE OF PHYSICIAN

[For use ONLY if the worker is NOT subject to a Certified Workplace Medical Plan (CWMP).]

Respondent rejects the three (3) physicians named in Claimant's Form-A Application for Change of Physician bearing a file-stamped date of _______________, _____, and presents to claimant the following list of three (3) physicians qualified to treat the claimant's injured body part for which the change of physician is sought:

(1)____

(2)____

(3)____

***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.**

Signed this________________day of______________________,___________.

Signature of Filing Party		
Address (Number & Street)		
City	**State**	**Zip Code**
Telephone # of Filing Party		
Print or type name of Attorney		**OBA #**

I HEREBY CERTIFY THAT ON THIS _______ DAY OF _____________________, _________ A COPY OF THIS FORM WAS MAILED, POSTAGE PREPAID, TO:

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

Rev. 06/24/2015