FORM A

Send original to
Court of Existing Claims and
1 copy to Each Opposing Party/Counsel

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)	WCC FILE NO.
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured	Date of Injury

CLAIMANT'S APPLICATION FOR CHANGE OF PHYSICIAN AND REQUEST FOR HEARING

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

Pursuant to 85 O.S., Section 326(E), CLAIMANT herein respectfully requests that the above captioned matter be set for hearing on the issue of change of physician. In support of this application, claimant states as follows:

1. Claimant is not subject to a certified workplace medical plan.

2. The limit set forth in 85 O.S., §326(E) of no more than two changes of physician per claim, regardless of the number of body parts injured, will not be exceeded if this application for change of physician is allowed.

3. A change of physician is sought for treatment of claimant's _____(state injured body part), for which authorized medical care has been provided for one hundred eighty (180) days prior to the date of filing this Application.

4. The name of claimant's current treating physician for the injured body part is _____.

5. Claimant presents to the employer/respondent the following list of three (3) physicians qualified to treat the claimant's injured body part for which a 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 Claimant	Print or Type Name of Attorney for Claimant, if any OBA #
Claimant's Address (Number and Street)	Signature of Attorney for Claimant
City State Zip	Claimant's Attorney's Address (Number and Street)
Claimant's Telephone Number	City State Zip
	Claimant's Attorney's Telephone Number

CERTIFICATE OF SERVICE

This is to certify that on this _____ day of _____, _____, the foregoing instrument was mailed, postage prepaid to:

Opposing Party/Counsel	Opposing Party/Counsel
Address (Number and Street)	Address (Number and Street)
City State Zip	City State Zip

_____
Signature of Claimant or Claimant's Attorney, if any.