STATE OF OKLAHOMA WORKERS' COMPENSATION COURT
COPY REQUEST FORM

FOR COURT USE ONLY

RMD-001 (REVISED 02/06/02)

SUBMIT REQUEST FORM TO

OKLAHOMA WORKERS' COMPENSATION COURT
ATTENTION: COPY REQUESTS
1915 NORTH STILES
OKLAHOMA CITY, OK 73105-4918

COPIES TO BE RETURNED TO

COMPANY NAME: _____
ATTENTION: _____ TELEPHONE: (____) _____
ADDRESS: _____
CITY/STATE/ZIP: _____

FOR EACH CASE NUMBER YOU MUST

1. USE A SEPARATE COPY REQUEST FORM, AND
2. INCLUDE A "REQUEST FOR CLAIMS FILE INFORMATION" CARD AND A $1 SEARCH FEE, UNLESS REQUEST IS EXEMPT, AS EVIDENCED BY YOUR SIGNATURE, BELOW

INQUIRIES

GENERAL INQUIRIES . . . RECORDS DEPT. (405) 522-8640
RECORDS MANAGEMENT DEPT. SUPERVISOR . . . SHERYL COLLINS (405) 522-8659

CLAIMANT'S NAME	DATE OF INJURY	WORKERS' COMPENSATION COURT CASE NO.

❒ **FORM 2** Employer's First Notice of Injury	❒ **FORM 14** Agreement Between Employer & Employee as to Fact with Relation to an Injury & Payment of Compensation
❒ **FORM 3** Employee's First Notice of Accidental Injury & Claim for Compensation	❒ **JOINT PETITION** Joint Agreement Between Parties Involved to Settle All Claims Against the Respondent & Insurance Carrier
❒ **FORM 3-A** Claimant's First Notice of Death & Claim for Compensation	❒ **ORDER** Entered On ____/____/____ ❒ **ALL ORDERS**
❒ **FORM 3-B** Employee's First Notice of Occupational Disease & Claim for Compensation	❒ **ENTRIES OF APPEARANCE** ❒ **SUBSTITUTIONS OF COUNSEL** ❒ **ATTORNEY WITHDRAWALS**
❒ **FORM 3-F** Employee's Claim for Benefits from the Special Indemnity Fund	❒ **MEDICAL REPORTS OF DR.** _____
❒ **FORM 3-E** Employee's Claim for Benefits for Combined Disabilities Against Last Employer	❒ **ALL MEDICAL REPORTS**
❒ **FORM 9** Motion to Set for Trial ❒ **WITH ATTACHMENTS**	❒ **FORM 19** Request for Payment of Charges for Medical or Rehabilitative Service Notice of Appeal of Administrative Order
❒ **FORM 10** Answer & Pretrial Stipulation Offered by Respondent ❒ **WITH ATTACHMENTS**	❒ **FORM 20** Proof of Loss in Death Claim
❒ **FORM 13** Request for Prehearing Conference	❒ **ENTIRE FILE** Files May Contain Duplicate Documents . . . BILLING IS FOR ALL COPIES, INCLUDING DUPLICATES
❒ **FORM N** Request to Set on the Accelerated Docket	❒ **OTHER** (Specify)

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.

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

INVOICE NO: _____
(NOTE: ALL APPLICABLE SEARCH FEES MUST ACCOMPANY REQUESTS AND WILL NOT BE BILLED)

_____ TOTAL COPIES ([1]FIRST COPY $1.00/ADDITIONAL COPIES 50¢ EACH) ..... $_____
[1]PURSUANT TO 85 O.S. §95

POSTAGE ..... $_____

TOTAL INVOICE AMOUNT ..... $_____

INVOICE DATE: ____/____/____

TERMS:
DUE IN 30 DAYS