FORM 100

Send original + 3 copies to
Workers' Compensation Court

WORKERS' COMPENSATION COURT
1915 NORTH STILES
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
Name of Employer or Respondent
Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured

CLAIMANT'S APPLICATION AND ORDER FOR DISMISSAL

COURT CLAIM NO.
Date of Injury

COMES NOW the CLAIMANT in the above-captioned matter and requests that this Court dismiss this claim pursuant to 85 O.S. § 43(B). In support of this application, movant states as follows:

[Note: A claim may be refiled no later than 1 year from the date the "Order of Dismissal Without Prejudice" is filed, even if the statute of limitations has run.]

YES	NO	Please mark the appropriate YES/NO response to the left of each numbered question.
_____	_____	1. The filing fee of $75.00 has been paid and a receipt evidencing payment is attached to this application.
_____	_____	2. The claimant is represented by counsel.
_____	_____	3. An order awarding permanent total disability has been entered by the Court, as a result of Trial, Form 14 Settlement or Joint Petition Settlement.
_____	_____	4. An order awarding permanent partial disability has been entered by the Court, as a result of Trial, Form 14 Settlement or Joint Petition Settlement.
_____	_____	5. 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: A dismissal order is permissible prior to final submission of the case to the Court for decision.*]

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.

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 for Claimant	

IT IS THEREFORE ORDERED, for good cause shown, that the above captioned case 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

11/01