CC-JOINT PETITION

Send original and 5 copies to the Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

FILED
SEP 20 2018
WORKERS' COMPENSATION COMMISSION
TULSA

In re: Claim of: (Please type or Print ALL information legibly in ink.)

Claimant's Full Name (Injured Employee) Charles A. Misener	Commission File Number CM2017-03271A
Injured Employee's Social Security Number (LAST 4 DIGITS ONLY) XXX-XX-6741	Date of Injury Aproximately July 2015
Name of Employer City of Broken Arrow	*Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony, punishable by imprisonment, a fine or both.*
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group, Uninsured Own Risk #14157	

JOINT PETITION SETTLEMENT

This agreement is prepared and submitted pursuant to Sections 87 and 115 of the Administrative Workers' Compensation Act, Title 85A of the Oklahoma Statutes. By signing below, each party affirms that they have read and understand its provisions, declares under penalty of perjury that all statements are true and accurate to the best of their knowledge and belief, and understand that the agreement, if approved by the Workers' Compensation Commission, is conclusive, final and binding on all the parties involved.

BY THIS AGREEMENT, the parties settle upon and determine (check one):

☒ **ALL ISSUES AND MATTERS IN THE CLAIM**
(Settlement and Resolution of Claim With Full Release)

☐ **SOME, BUT NOT ALL, ISSUES AND MATTERS IN THE CLAIM** – Attach appendix of all outstanding issues. The appendix is subject to approval by the Workers' Compensation Commission. It MUST accompany the CC-JOINT PETITION, and be dated and signed by all parties under penalty of perjury.

1. It is hereby agreed by and between the above named parties that the claimant alleges to have sustained a compensable accidental injury or occupational disease or illness on or about Aprroximately July 2015, while in the employ of the employer, causing the following injury (describe nature of injury) Left Shoulder, and resulting in **temporary total disability** from IL paid, or for a period of _____ weeks, _____ days, for which the claimant received All Paid in compensation from the employer/insurance carrier. The claimant's average weekly wage before the injury entitles the claimant to a compensation rate of $571.55 for Temporary Total Disability and $323.00 for Permanent Partial Disability.
2. A claim for compensation was filed by the claimant for the injury, or, if the claimant is not represented by an attorney, an Employer's First Notice of Injury (CC-Form-2) was filed by the employer for the injury, and the Workers' Compensation Commission has jurisdiction in this matter.
3. This is an agreement in which the claimant agreed to accept $ 16,957.50 in full and final settlement of all claims for: *(describe injury)* Left Shoulder and any known or unknown body parts related to the injury on Aprroximately July 2015 sustained as a result of the accident referred to above, including any claim by the claimant for the past, present and future compensation for temporary total disability, temporary partial disability, permanent partial disability or permanent total disability, statutory medical treatment, physical and vocational rehabilitation benefits, or loss of wage earning capacity, as a result of any and all injuries sustained in the accident. This sum is in addition to any previous amount(s) paid to the Claimant, and any amount(s) for authorized, reasonable and necessary medical and rehabilitative expenses previously incurred by the claimant due to the injury. Of said sum, $16,957.50 shall be paid for permanent partial disability (15%) to Left Shoulder and $ _____ shall be paid for _____
. Settlement includes payment of any unpaid requests for reimbursements of mileage, prescriptions, or other out of pocket expenses.
4. *For Social Security offset purposes, and if applicable, the claimant agrees to accept and the employer/carrier agrees to pay a lump sum of $ _____ for permanent impairment that will affect the claimant for the rest of the claimant's life. The claimant's remaining life expectancy is _____ months. Therefore, even though paid in a lump sum, claimant's benefit (after deduction of attorney fees and expenses) shall be considered to be $ _____ a month for _____ months, beginning ____.*
5. The sum of $ 3,391.50 shall be deducted from this settlement and paid to the claimant's attorney pursuant to the workers' compensation laws of the state.
6. The employer/carrier agrees to pay all applicable Commission costs, and all taxes and assessments to the Oklahoma Tax Commission, as follows: $140.00 to the Workers' Compensation Commission, taxed as costs in this matter, unless previously paid; the Special Occupational Health and Safety Tax in the sum of $ 127.18, representing three-fourths of one percent (0.75%) of the joint petition settlement amount, excluding medical payments and temporary total disability compensation; if a Commission Approved OWN RISK employer or group self-insurance association, the Workers' Compensation Fund assessment in the sum of $339.15, representing 2% of the joint petition settlement amount, and, if applicable, the Self-Insurance Guaranty Fund assessment in the sum of $ _____, representing 1% of the joint petition settlement amount; and, in addition to other amounts, if UNINSURED, a Multiple Injury Trust Fund assessment in the sum of $ _____, representing 5% of the joint petition settlement amount.

Administrative Workers' Compensation Act, 85A O.S.,§6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment...shall be guilty of a felony."

Charles A. Misener
CLAIMANT NAME – PLEASE PRINT

226 East Dallas Street, Broken Arrow, OK, 74012
CLAIMANT ADDRESS

Charles A. Misener
CLAIMANT – SIGNATURE DATE

J. L. Franks 10061
NAME OF CLAIMANT ATTORNEY, if any – PLEASE PRINT OBA #

CLAIMANT ATTORNEY – SIGNATURE DATE 9/20/18

City of Broken Arrow
EMPLOYER NAME – PLEASE PRINT

Kymberly J Watt 15797
NAME OF EMPLOYER/CARRIER'S ATTORNEY – PLEASE PRINT OBA #

Own Risk #14157
NAME OF EMPLOYER'S CARRIER OR OWN RISK GROUP – PLEASE PRINT

EMPLOYER/CARRIER ATTORNEY – SIGNATURE DATE

ORDER APPROVING JOINT PETITION SETTLEMENT: The Workers' Compensation Commission, having reviewed the evidence, files and records in this matter and being fully advised in the premises, approves the above Joint Petition Settlement, including the attorney fees, if any, and the attached appendix to the Joint Petition Settlement, if any, which Joint Petition Settlement and appendix are incorporated herein by reference and made a part hereof. If a child support lien were filed in this workers' compensation case, the employer/carrier shall include the name of the person or government agency asserting the lien on any check for temporary total disability, permanent partial disability and permanent total disability. The employer/carrier shall comply with this order within twenty (20) days from the file stamped date of the order. In that event, and if the Joint Petition Settlement determined all issues and matters in the claim, this cause shall be fully and finally closed and resolved, and the Commission divested of further jurisdiction therein.

DONE this ___ day of _____, 2018.
A copy hereof was mailed by United States regular mail on this file-stamped date to all Attorney of record and unrepresented parties.

BY ORDER OF _____
ADMINISTRATIVE LAW JUDGE

Before the Workers' Compensation Commission of the State of Oklaho

FILED
SEP 20 2018
WORKERS' COMPENSATION COMMISSION TULSA

In re claim of:

Charles A. Misener
Claimant

City of Broken Arrow
Respondent

Own Risk #14157
Insurance Carrier

Commission File Number: CM2017-03271A

Claimant's Social Security Number XXX-XX-8741
(LAST 4 DIGITS ONLY)

CERTIFICATE TO JOINT PETITION

1. The claimant certifies that the Respondent has been notified of all medical providers who have provided medical treatment, including physical therapy, as a result of the accidental injury or occupational disease or illness while employed by Respondent. A list of all medical providers who have provided treatment is attached hereto as Exhibit A.

   Further, the Claimant represents and agrees to notify all future medical providers for the accidental injury or occupational disease or illness while employed by the Respondent that the claim against the Respondent has been fully settled by Joint Petition Settlement.

Claimant

2. The Respondent certifies that a copy of the Joint Petition Settlement will be provided to all known medical providers, including physical therapists, who have provided treatment to the claimant, within ten (10) days of the settlement. The Respondent shall also notify the medical providers that the Joint Petition Settlement specifies that the Respondent will not be responsible for treatment rendered after the date of the Joint Petition Settlement.

Respondent

Administrative Workers' Compensation Act, 85A O.S., §6(A)(1)(a): "Any person or entity who makes any material false statement or representation, who willfully and knowingly omits or conceals any material information, or who employs any device, scheme, or artifice, or who aids and abets any person for the purpose of: (1) obtaining any benefit or payment ... shall be guilty of a felony."

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment, a fine or both.

- over -

EXHIBIT "A" TO CERTIFICATE TO JOINT PETITION

The following Medical Providers have provided medical treatment, including physical therapy, as a result of the accidental injury or occupational disease or illness while employed by Respondent:

Name	Address City State Zip
Dr. Gillock	**7170 S. Braden Ave., Tulsa, OK**
Dr. Rao	**5544 S. Lewis Ave., Ste 500, Tulsa, OK**