CC-JOINT PETITION

Send original and 6 copies to the Workers' Compensation Commission

WORKERS' COMPENSATION COMMISSION
1915 NORTH STILES AVENUE STE 231
OKLAHOMA CITY, OK 73105

THIS SPACE FOR COMMISSION USE ONLY

ORDER FILED
SEP 14 2020
WORKERS' COMPENSATION COMMISSION

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

Claimant's Full Name (Injured Employee) Michael M. Jackson	Commission File Number CM2020-02710R
Injured Employee's Social Security Number (LAST 5 DIGITS ONLY) XXX-X2366	Date of Injury 10-1-18 single and DOA
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 Individual Self-Insured or Own Risk Group, Uninsured Own Risk #14157	

JOINT PETITION SETTLEMENT

This agreement is prepared and submitted pursuant to 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 understands 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 10-1-18 single event and DOA while in the employ of the employer, causing the following injury (describe nature of injury) Arms, Hands *Neck and Shoulder denied by Respondent and resulting in temporary total disability from Injury Leave, or for a period of ____ weeks, ____ days, for which the claimant received $ ____ in compensation from the employer/insurance carrier. The claimant's average weekly wage before the injury entitles the claimant to a compensation rate of $ 590.63 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 agrees to accept $ 46,835.00 in full and final settlement of all claims for (describe injury), Arms, Hands * Neck and Shoulders denied by Respondent, and any other known or unknown injury relating to the injury on 10-1-18 sustained as a result of the accident referred to above, including any claim by the claimant for 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 an d rehabilitative expenses previously incurred by the claimant due to the injury. Of said sum, $ 46,835.00 shall be paid for permanent partial disability (41.4%) to WM (hands, arms) and $ n/a shall be paid for *Settlement includes any outstanding reimbursements including prescriptions, mileage and medical. Injury to the Shoulders and Neck is denied. Section 89 credit waived.
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 $ 9,367.00 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 $ ____ 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 $ 351.26, 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 $ 936.70, representing 2% 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. For injuries occurring on or after 7/1/19: The CLAIMANT agrees to pay taxes and assessments as follows: Multiple Injury Trust Fund assessment in the amount of $ n/a representing three percent (3%) of the joint petition settlement amount attributable to permanent partial disability or permanent total disability, shall be deducted from the settlement amount and paid by the employer.

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."

Michael M. Jackson CLAIMANT NAME — PLEASE PRINT	City of Broken Arrow EMPLOYER NAME — PLEASE PRINT
18432 S. 4180 Rd., Claremore, OK 74017 CLAIMANT ADDRESS	Leah P Keele 15483 NAME OF EMPLOYER/CARRIER'S ATTORNEY — PLEASE PRINT OBA#
09/7/2020 CLAIMANT — SIGNATURE DATE	Own Risk #14157 NAME OF EMPLOYER'S CARRIER OR OWN RISK GROUP — PLEASE PRINT
Robert Flynn 9/7/2020 NAME OF CLAIMANT ATTORNEY, if any — PLEASE PRINT OBA #	Leah P. Keele 9-14-20 EMPLOYER/CARRIER ATTORNEY — SIGNATURE DATE
CLAIMANT 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 Joint Petition Settlement, including 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 was 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 or 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 2nd day of September, 2020

Reporter's Initials

A copy hereof was mailed by United States regular mail on this file-stamped date to all attorneys of record and unrepresented parties.

BY ORDER OF Tara A. Talbot
ADMINISTRATIVE LAW JUDGE

Before the Workers' Compensation Commission of the State of Oklahoma

ORDER FILED
SEP 14 2020
WORKERS' COMPENSATION COMMISSION

In re claim of:

Michael M. Jackson, Claimant	)	Commission File #: CM2020-02710R
City of Broken Arrow, Respondent	)	Claimant's Social Security Number XXX-X000-00-2358 - (LAST 5 DIGITS ONLY)
Own Risk #14157, Insurance Carrier	)	

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.

   Leah P. Keele
   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.

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
Advanced Orthopedics	2488 E. 81st Street, Tulsa, OK 74136
Oklahoma Surgical Hospital	2448 E. 81st Street, Tulsa, OK 74137
Dr. Bretton Jameson	511 S. Windsor, Stillwater, OK 74074
MedNow	503 S. Aspen, Broken Arrow, OK 74012
Central States Orthopedics	6585 S. Yale Ave., Ste. 200, Tulsa, OK 74136
Harvard Family Physicians	7912 E. 31st Court, Tulsa, OK 74145
Dr. Kenneth R. Trinidad	1006 W. 23rd St., Tulsa, OK 74107