FORM 17

Send original to
Workers' Compensation Court
Attention: Medical Services Division

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

DISCLOSURE STATEMENT

Physicians providing treatment under the Workers' Compensation Act or applying to serve as a Court appointed Independent Medical Examiner must complete this form. Any change in information must be reported to the Workers' Compensation Court as soon as practicable after such change by filing another Form 17 marked "AMENDED". All reported information must be updated annually. **ALL INFORMATION SUBMITTED TO THE COURT MAY BE CONSIDERED A PUBLIC RECORD UNDER STATE LAW.** Direct questions concerning disclosures to the Medical Services Division.

(Please type or print)

Physician Information

Physician Name:		Professional License #:
Address:		
City:	State:	Zip:

• PART I. Disclosure of Interests in Health Care Facilities. (85 O.S., § 17 and § 201)

If you are a physician providing treatment under the Workers' Compensation Act or applying as a Court appointed Independent Medical Examiner, you must disclose to the Workers' Compensation Court Administrator any ownership or interest in any health care facility that is not the physician's primary place of business. This includes, but is not limited to, disclosure of any leasing agreement between the physician and health care facility. (Attach supplemental pages as necessary. If you have no disclosures, state "NONE".)

Health Care Facility (ies):	Employee Leasing Arrangement? ☐ Yes ☐ No	
Address:		
City:	State:	Zip:

Health Care Facility (ies):	Employee Leasing Arrangement? ☐ Yes ☐ No	
Address:		
City:	State:	Zip:

• PART II. Disclosure of Contractual Relationships. (85 O.S., § 17)

If you are a physician applying to serve as a Court appointed Independent Medical Examiner, give the following information: Name and address of any employer, insurer, employee group, certified workplace medical plan (including the name and address of the Administrator of any such plan), with whom the physician is under contract to treat workers' compensation injuries, or serves as a company doctor. (Attach supplemental pages as necessary. If you have no disclosures, state "NONE".)

Please check (✓) the appropriate boxes

Entity Name: 1			☐ **Contract**
Address:			☐ **Certified Workplace Medical Plan**
City:	State:	Zip:	☐ **Company Doctor**
Entity Name: 2			☐ **Contract**
Address:			☐ **Certified Workplace Medical Plan**
City:	State:	Zip:	☐ **Company Doctor**
Entity Name: 3			☐ **Contract**
Address:			☐ **Certified Workplace Medical Plan**
City:	State:	Zip:	☐ **Company Doctor**

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 ______________, ________

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Signature of Physician