Rule 1.301, Form No. 9

IN THE SUPREME COURT OF THE STATE OF OKLAHOMA

_____	)	
_____	)	
_____,	)	
_____	)	
Petitioner,	)	
v. _____	)	_____
_____	)	No. _____
_____,and	)	_____
THE WORKERS' COMPENSATION	)	_____
COMMISSION or THE WORKERS' COMPENSATION COURT OF EXISTING CLAIMS,	)	
Respondents.	)	

PETITION FOR REVIEW

A. WORKERS' COMPENSATION COMMISSION or THE WORKERS' COMPENSATION COURT OF EXISTING CLAIMS HISTORY

Number and style of proceeding in the court: _____
Decision to be reviewed was rendered by: (Check one)

( ) The Workers' Compensation Commission, or
( ) The Workers' Compensation Court of Existing Claims en banc panel, or
( ) A Judge of the Court of Existing Claims.

Date of filing of the decision to be reviewed? _____

Date a copy of the decision was sent to the parties? _____

B. DISPOSITION IN THE WORKERS' COMPENSATION COMMISSION or WORKERS' COMPENSATION COURT OF EXISTING CLAIMS

Nature of the decision to be reviewed _____
Relief sought: _____
Relief granted: _____

(Attach a certified copy of the decision to be reviewed as exhibit "A".)

If the Decision to be reviewed is from the Workers' Compensation Commission, also attach a certified copy of the underlying decision of the administrative law judge:

If the Decision to be reviewed is from the Workers' Compensation Court of Existing Claims en banc panel, also attach a certified copy of the underlying decision of the Judge of the Court.)

C. BRIEF SUMMARY OF PROCEEDING

Exhibit "B" attached (not to exceed one 8 1/2 x 11" double spaced page).

D. ISSUES AND ERRORS PROPOSED TO BE RAISED ON APPEAL

Exhibit "C" attached. (Number and state with specificity each point urged as error.) (General assignments will not suffice.)

ANY RELATED OR PRIOR APPEALS? ____ YES ____ NO
(Identify by style, citation, if any, and Supreme Court Number.)

Style	Citation	Supreme Court No.
_____	_____	_____
_____	_____	_____
_____	_____	_____

E. ATTORNEY FOR PETITIONER

Name:_____
Firm: _____
Address: _____
_____
Telephone: _____

ATTORNEY FOR RESPONDENT

Name: :_____
Firm: _____
Address: _____
_____
Telephone: _____

(Give the name and address of the party if unrepresented)

Date: _____, 20____

_____
Verified by (Signature of Attorney or Pro Se Party)

_____
OBA No.

_____
Firm

_____
Designated Case-Specific Email Address *[if applicable]*

_____
Secondary Email Address *[if applicable]*

_____
Address

_____
Telephone

CERTIFICATE OF FILING AND MAILING

I _____, do hereby certify that on this _____ day of _____, 20_____, I filed with the Workers' Compensation Commission or the Workers' Compensation Court of Existing Claims, a correct copy of the Petition for Review with attachment(s), and also mailed a copy with attachment(s) to each party to the proceeding or his counsel of record as follows:

[Names and addresses of all parties or counsel of record]