

**IN THE DISTRICT COURT FOR THE CHOCTAW NATION OF OKLAHOMA**

 INSTRUCTIONS and CRITERIA TO FILE A WORKERS’ COMPENSATION APPEAL

1. Read all instructions carefully.
2. The criteria to file a worker’s compensation appeal through the Choctaw Nation District Court can be found in the Choctaw Nation Workers’ Compensation Code (“CNO WC Code”) at Article 9 and includes the following:
	1. Any appeal must be filed within 30 days of the date an employee receives a written decision of denial of a claim by the Administrator or when the claim is deemed denied pursuant to Section 5-107 of CNO WC Code.
	2. The claimant must sign a Verification (form will be provided by Court Clerk.)
	3. A fee of $100.00 is required at the time of filing. This fee is payable by debit or credit card, cashier check or money order payable to CHOCTAW NATION.
3. You must file a Notice of Appeal with the District Court. The Notice of Appeal must contain the following:
	1. Completed WIFORM
	2. A brief summary of the relevant facts
	3. A brief statement of the disputed issues
	4. A brief statement of the relief sought
	5. All other evidence or data necessary for consideration of the claim
	6. A copy of the final Administration decision being appealed.
	7. A signed declaration that the information submitted is true and correct to the best of your knowledge
4. We have provided an editable version of the Workers’ Compensation Notice of Appeal form. There are highlighted directions contained within the editable version that need to be deleted before printing your forms. You must file your own Notice of Appeal to have your claim filed in Choctaw Nation District Court for your case to be heard by the Judge.
5. All documents submitted when you file a Notice of Appeal must be on 8 1/2” x 11” letter-size paper. Print on ONE SIDE ONLY of each page. Use as many or few pages as needed for your situation. You must sign in front of a notary.

IMPORTANT: These Instructions and Criteria are ONLY a guide to help you prepare your Notice of Appeal and you are required to comply with all statutory requirements of the CNO WC Code.. The Choctaw Nation District Court and Court Clerk’s office do not provide lawyers, legal advice, or legal assistance. If you need/want legal advice or representation, you must retain your own lawyer at your own expense. If you select a lawyer to represent you, he/she must be registered to practice law with the Choctaw Bar.

ENCLOSE THE FOLLOWING WITH YOUR PETITION:

We have provided a Notice of Appeal Form as a guide below. When you are ready to mail or personally bring your Notice of Appeal to be filed with the Court Clerk’s office, you MUST bring or mail in the following to file your Worker’s Notice of Appeal:

1. Information Sheet (THIS MUST BE FILLED OUT AND RETURNED WITH NOTICE OF APPEAL).
2. Debit or credit card, cashiers check or money order for $100.00 payable to Choctaw Nation.

If you do not file your Notice of Appeal timely (within 30 days of when you receive your Closure Letter or when the claim is deemed denied pursuant to Section 5-107 of CNO WC Code) and correctly (as required by statute and GUIDED in this document), your claim may not be accepted by the District Court. The Choctaw Nation of Oklahoma Codes can be obtained from the Nation’s website or upon request of the Court.

If you have questions, you may reach the Court Clerk by phone at (580) 920-7027. Mail all correspondence to P.O. Box 1160, Durant, OK 74702. The Choctaw Nation District Court. The Court Clerk’s office is in the Choctaw Nation Judicial Center at 2250 Chukka Hina Drive, Durant, OK 74701.



**IN THE DISTRICT COURT FOR THE CHOCTAW NATION OF OKLAHOMA**

TYPE OF CASE

Workers’ Compensation

PETITIONER/PLAINTIFF/CLAIMANT INFORMATION

NAME: Last: First: Middle:

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: STATE: ZIP:

DATE OF BIRTH:

TELEPHONE: ALTERNATE NUMBER:

Please use this phone number to call for credit/debit card payment.

E-MAIL:

TRIBAL AFFILIATION:

RESPONDENT/DEFENDANT INFORMATION

NAME: Choctaw Nation of Oklahoma Workers’ Compensation Administrator

ADDRESS: P.O. Box 1210

CITY: Durant STATE: OK ZIP: 74702 TELEPHONE: 1-800-522-6170



**IN THE DISTRICT COURT FOR THE CHOCTAW NATION OF OKLAHOMA**

Petitioner CASE NO. WI-

VS.

Choctaw Nation of Oklahoma Workers’ Compensation Administrator Respondent

 NOTICE OF APPEAL OF WORKERS’ COMPENSATION ADMINISTRATIVE DECISION

Comes now the Petitioner, and files this Notice of Appeal of the Administrative decision of the Choctaw Nation of Oklahoma Workers’ Compensation Department, in the District Court for the Choctaw Nation of Oklahoma, and alleges and states under oath that the following information is true and correct:

1. That the District Court for the Choctaw Nation of Oklahoma has the authority to hear and decide this matter according to Section 9-101 of the Choctaw Nation of Oklahoma Workers’ Compensation Code of 2020 (“CNO WC Code”).
2. That the District Court for the Choctaw Nation of Oklahoma has personal jurisdiction to hear and decide this matter because the Petitioner stipulates to the jurisdiction of the court and: (choose A or B that applies to your situation and delete the other.)
	1. The Petitioner is currently, and was at the time, the injury giving rise to the original claim, an employee of the Choctaw Nation of Oklahoma.
	2. The Petitioner was at the time, of the injury, giving rise to the original claim an employee of the Choctaw Nation of Oklahoma.
3. That the Choctaw Nation of Oklahoma Workers’ Compensation Department issued a final administrative decision related to Petitioner’s claim on (date) which was received by Petitioner on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date).
4. That the Petitioner has filed this Notice of Appeal within thirty (30) days of the date of when Petitioner received the Administrator’s decision or within thirty (30) days of the date when Petitioner’s claim was deemed denied, pursuant to Section 5-107 of CNO WC Code, therefore making this appeal timely filed.
5. That the Petitioner does not agree with all or part of the Administrator’s decision and is therefore requesting this Court review the matter and the decision.
6. That Petitioner has complied with all statutory requirements of Section 9-103 of the CNO WC Code in filing this Notice of Appeal and has included the following documents with this Notice of Appeal: (list only the documents you are submitting)
	1. Completed Workers’ Compensation Form (WIFORM, see below);
	2. A brief summary of the relevant facts (What happened);
	3. A brief statement of the disputed issues (What don’t you agree with);
	4. A brief statement of the relief sought (What do are you asking for);
	5. All other evidence or data necessary for consideration of the claim (Anything else you think the Court should know);
	6. A copy of the final administrative decision being appealed (Copy of the Claim Closure Letter you received);
	7. A signed declaration that the information submitted is true and correct to the best of your knowledge (Verification, see below);
7. That the Petitioner hereby consents to and requests release of a copy of his/her Workers’ Compensation case file be sent to the District Court of the Choctaw Nation of Oklahoma by the Administrator.
8. The Petitioner hereby requests the District Court review the claim and decision of the Administrator and determine final disposition of this claim, per CNO WC Code, Article 9.
9. The Petitioner hereby requests in the event of an award in the Petitioner’s favor, the Petitioner shall be reimbursed any court costs and filing fees previously paid in filing this Notice of Appeal, per Section 9-108 (A) of CNO WC Code.
10. In the case of a lump sum compromise or settlement of an appeal, Petitioner seeks attorneys’ fees, not to exceed ten (10%) percent of the actual lump sum settlement awarded, per Section 9-109 (B) of CNO WC Code.

WHEREFORE, the Petitioner prays that upon review and/or hearing this case, the court grant and award disposition in the Petitioner’s favor and all the relief requested herein and such other and further relief as to which the Petitioner may be entitled.

Petitioner’s Signature:

Petitioner’s Name:

Petitioner’s Address:

Alternate Phone Number Where Petitioner May Be Reached:

VERIFICATION

STATE OF OKLAHOMA
COUNTY OF

 , being of lawful age, being first duly sworn upon oath, states:

That he/she is the Petitioner above named; that he/she has read the foregoing Notice of Appeal, and any attachments thereto, knows the contents thereof and understand the same, and that the facts therein set forth are true and correct.

Petitioner

Subscribed and sworn to before me this day of , 20 .

(Notary Seal) Notary Public

My Commission Exp.:

My Commission Number.:

WORKERS’ COMPENSATION FORM (WIFORM)

Court Stamp Case#

|  |  |  |
| --- | --- | --- |
| Employee Name (Last, First, Middle): | Social Security #: | Phone: |
| Mailing Address (include City, State, & Zip): | Date of Birth: Age: | Sex: |
| Occupation: | Av. Weekly Wage: | Length of Employment:Years Months |
| Date of Accident: | Time Injury Occurred:AM/PM | Place of Injury:City/County/State |

|  |
| --- |
| Describe parts of the body injured or affected: |
| What is the nature of the Injury or Illness? |
| Describe with details how the injury occurred. Include object or substance which directly injured you: |

Are you previously impaired due to a prior workers’ compensation claim?

I declare under penalty of perjury that I have examined this notice and claim, and all statements continued 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, may be subject to criminal charges.

Name of claimant’s attorney if represented:

|  |  |
| --- | --- |
| Name of Attorney: | OBA #: |
| Mailing Address (include City, State, & Zip}: |
| Telephone: |

Signature of Attorney for Claimant

Upon filing this Notice of Accidental Compensation and Claim for Injury, permission is given to the Choctaw Nation District Court, Administrator of the Workers’ Compensation Policy, or their designees to examine all records relating to this notice.

Signed this day of , 20

Signature of Claimant (must be signed by claimant)

This form is not intended for use as a medical authorization.

Nothing contained in this form shall be construed to waive the sovereign rights of the Choctaw Nation of Oklahoma, any subsidiaries and affiliates of the Choctaw Nation of Oklahoma or any of their respective officers, directors, servants, agents, employees, successors or assignees.