RELEASE OF ALL CLAIMS AND COVENANT NOT TO APPEAL

THIS RELEASE OF ALL CLAIMS AND COVENANT NOT TO APPEAL (the "Release") is entered into this 13th day of May, 2019, by and between, Claimant, Robert "Shane" Rohr (the "Releasor"); and the Respondent, City of Norman, Oklahoma, self-insured, (the "Releasee").

WHEREAS, the Releasor has filed an action in the Oklahoma Workers' Compensation Commission, State of Oklahoma styled: Robert "Shane" Rohr v. City of Norman, Oklahoma, CM-2017-01333 R, seeking damages against the Releasee as a result of an alleged accident that occurred on or about February 11, 2016, as more fully set forth in the Form 3 (Attachment 1) filed in this matter;

WHEREAS, in consideration of the settlement set forth below, Releasor is willing to enter into this Release with Releasees;

WHEREAS, although Releasees have expressly denied any and all responsibility or liability to Releasor as a result of the alleged accident, the parties are desirous of settling their differences by executing this Release.

NOW THEREFORE, in consideration of the foregoing, it is agreed by Releasor and Releasees and their respective attorneys as follows:

1. **CONSIDERATION:**

(a) Releasees hereby agrees to pay the Releasor, Robert "Shane" Rohr, the sum of Twenty Thousand Three Hundred Forty-Nine Dollars ($20,349);

(b) Releasor agrees to satisfy any and all outstanding hospital, physician, or attorney liens or any other claims and provide Releasees with lien releases, if any.

2. **SCOPE OF THIS AGREEMENT:**

In consideration for the above-described payment, Releasor hereby releases and forever discharges Releasee, and its respective officers, directors, employees, agents, representatives, affiliates, successors, and assigns that are or may be liable for any and all all claims of any kind or character which the undersigned, individually, and in all other capacities, now has or under any circumstances could or might have against the Releasees herein relating in any way to the alleged accident which occurred on or about February 11, 2016.

RELEASOR FURTHER REPRESENTS that no promise or condition not herein specifically set forth has been made to him and that he is fully aware of the terms of this Release. Releasor fully warrants that he is authorized in the premises and competent to execute this Release for the purposes set forth herein. The undersigned agrees that the payment described herein constitutes the total compensation which will ever be paid to him and all persons whom the undersigned represents by reason of the claim or claims which have been made or may ever be made against the parties released hereby for damages or arising from or any way related to the alleged accident which occurred on or about February 11, 2016, as more fully set forth in the Form 3 (Attachment 1) filed by the Releasor with the Oklahoma Workers' Compensation Commission, Case No. CM-2017-01333 R.

IT IS FURTHER AGREED that this Release shall be final and binding upon all parties, their heirs, successors and assigns of whatever nature and description, and that no claim, be it derivative or otherwise, may ever be made against the parties released with respect to the matters covered by this Release. Releasor further warrants and represents that no portion of such claim has been assigned, subrogated or otherwise transferred to any person or legal entity which claims or may claim a legal right there under as against the released party. Releasor specifically states that all medical and/or legal expenses and medical and/or attorney liens have been fully satisfied

and that the Releasor will fully indemnify the Releasees from any outstanding medical and/or legal expenses and medical and/or attorney liens, if any.

IT IS FURTHER UNDERSTOOD AND AGREED that Releasor and Releasees covenant never to appeal, contest controvert, or contradict in any way any Order or Dismissal in said claim. Releasor further hereby covenants never to sue or prosecute Releasee or its subsidiaries, wholly owned companies, franchisees, successors, assigns, or transferees, for any claim the undersigned may have arising under the Americans With Disabilities Act of 1990 (ADA) and further agrees that he will not seek employment with the City of Norman, Oklahoma.

IT IS FURTHER UNDERSTOOD AND AGREED that the payment of the amount is not to be construed an admission of liability on the part of the Releasees.

IT IS FURTHER UNDERSTOOD AND AGREED that Releasor understands the settlement must be placed on a regularly scheduled Norman City Council agenda and approved by the Norman City Council prior to release of the settlement funds.

THIS RELEASE contains the entire agreement between the parties hereto and the terms of this Release are contractual and not a mere recital.

THE UNDERSIGNED HAS CAREFULLY READ THE FOREGOING RELEASE, understand the contents hereof, and signs the same as a result of his own free and voluntary act.

DATED this 13th day of May, 2019.

Robert Shane Rohr

Robert "Shane" Rohr
RELEASOR

READ, RATIFIED & APPROVED BY:

Richard Bell

ATTORNEY FOR CLAIMANT/RELEASOR

ATTESTATION

STATE OF OKLAHOMA)
) SS.
COUNTY OF Cleveland)

On this 9th day of May, 2019, before me, the undersigned notary public in and for said county and state, personally appeared Robert "Shane" Rohr, an individual, known to me to be the person named herein and whose name is subscribed to the foregoing Release of all Claims and Covenant Not to Appeal, and acknowledged that he executed the same as his free and voluntary act and deed.

Teresa Dew
Notary Public

NOTARY SEAL PUBLIC
TERESA DEW
Notary Public
State of Oklahoma
Commission # 02011610 Expires 07/22/22

My Commission Expires:

7-22-22

Attachment 1

FORM-3

FOR ACCIDENTAL INJURY OR CUMULATIVE TRAUMA OCCURRING ON OR AFTER FEBRUARY 1, 2014

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

THIS SPACE FOR COMMISSION USE ONLY

FILED
MAR 0 1 2017
6 WORKERS' COMPENSATION COMMISSION

Send original and 4 copies to:
Workers' Compensation Commission

Name of Claimant (Injured Employee): Robert "Shane" Rohr

Name of Employer: City of Norman

Commission Use Only: OK#10970

Please check appropriate box
- ☐ I. Original Filing
- ☐ II. Amends a previously filed CC- Form-3. (Must clearly state whether amendment is in addition to, or substitute for, prior information)

EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or In-State Toll Free (800) 522-8210.

COMMISSION FILE NO: 2017 01333R

(Please type or print)

FULL NAME OF EMPLOYEE (Last, First, Middle): Rohr, Robert "Shane"	Social Security Number (LAST 4 DIGITS ONLY): XXX-XX- 4322	Phone: 405-556-0969	
Mailing Address (include City, State & Zip): 1916 Twintree Dr. Norman OK 73071	Date of Birth: 10-13-66	Age: 50	Sex: m
Occupation: SANITATION WORKER	Was your employment agreement in Oklahoma? YES ☒ NO ☐	Average Weekly Wage: $840.00	Length of Employment: Date of Hire: 9 YRS
Date of Accident/ Injury: ON OR About 2-11-16	Injury resulted from: Single incident ☒ Cumulative Injury ☐	Time Injury Occurred ☐ AM ☐ PM	
Describe parts of the body injured or affected: Neck	Place of Injury: City/County/State: Norman OK		
What is the nature of the injury or illness: (not a soft tissue injury)	Describe with details how the injury occurred. Include object or substance which directly injured you: while driving SANITATION truck, hit bump in road and hit head on CABIN of truck		
Have you filed a claim for Social Security Disability Insurance Benefits? YES ☐ NO ☑	Are you eligible for Medicare Benefits within 30 months of the filing of this Notice of Accidental Injury and Claim for Compensation? YES ☐ NO ☑		

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? ___ If "YES", you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund. A claim against the Multiple Injury Trust Fund may be commenced by filing a "Form 3-F" with the Workers Compensation Court.

Treating Physician (full name): DR. Stewart Smith	Address:	City	State	Zip
Employer: City of Norman			Employer's FEI# (Federal ID Number):	Telephone:
Complete Mailing Address: 201 W. Gray	City: Norman	State: OK	73069	Zip:
Complete Street Address (if different from above):	City:	State:		Zip:

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall within seven (7) days report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

CLAIM INFORMATION (Please Print)

Is this a claim for initial benefits (i.e. no benefits, either medical or indemnity, have been received)? ☐ YES ☑ NO

Is this a claim for additional benefits (e.g. additional temporary total disability, additional medical? ☑ YES ☐ NO

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form: _____

Name of claimant's attorney if represented:

Type or Print Name of Attorney: RICHARD A. BELL	OBA# 685
Mailing Address: 3151 W. Tecumseh Rd., Suite 100	
City: NORMAN, State: OK Zip: 73072	
Telephone #: (405) 329-6850	

The undersigned declare under PENALTY OF PERJURY that they have examined this Employee's First Notice of Claim for Compensation, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this 28th day of Jan.

Robert Rohr
Signature of Claimant (must be signed by claimant)

Richard A. Bell
Signature of Attorney for Claimant (if any)

c. 02/01/14 ATTORNEY LIEN CLAIMED

CC-FORM-3-Amended

USE FOR ACCIDENTAL INJURY OR CUMULATIVE TRAUMA OCCURRING ON OR AFTER FEBRUARY 1, 2014

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

THIS SPACE FOR COMMISSION USE ONLY
FILED
OCT 16 2017
WORKERS' COMPENSATION COMMISSION

Send original and 4 copies to:
Workers' Compensation Commission

Name of Claimant (Injured Employee)
Robert ""Shane"" Rohr

Name of Employer
City of Norman

Commission Use Only OR 10970

✔ Please check appropriate box

☐ I. Original Filing

☒ II. Amends a previously filed CC- Form-3. (Must clearly state whether amendment is in addition to, or substitute for, prior information)

EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or In-State Toll Free (800) 522-8210.

COMMISSION FILE NO:
CM-2017-01333R

(Please type or print)

FULL NAME OF EMPLOYEE (Last, First, Middle)	Social Security Number (LAST 4 DIGITS ONLY):	Phone:
Rohr, Robert ""Shane""	XXX-XX-4322	

Mailing Address (include City, State & Zip):	Date of Birth:	Age:	Sex:
1916 Twintree Dr., Norman OK73071			

Occupation:	Was your employment agreement in Oklahoma? YES ☒ NO ☐	Average Weekly Wage:	Length of Employment	Date of Hire:

Date of Accident/ Injury:	Injury resulted from:	Time Injury Occurred
	Single incident ☐ Cumulative Injury ☒	☐ AM ☐ PM

Describe parts of the body injured or affected:	Place of Injury: City/County/State

What is the nature of the Injury or Illness: Cumulative & aggravation of a pre-existing condition to neck (not a soft tissue injury)	Describe with details how the injury occurred. Include object or substance which directly injured you:

Have you filed a claim for Social Security Disability Insurance Benefits?	Are you eligible for Medicare Benefits within 30 months of the filing of this Notice of Accidental Injury and Claim for Compensation?
YES ☐ NO ☐	YES ☐ NO ☐

Are you a previously impaired person due to a prior workers' compensation injury or obvious and apparent pre-existing disability? ___ If "YES", you may be entitled to benefits for combined disabilities against the Multiple Injury Trust Fund. A claim against the Multiple Injury Trust Fund may be commenced by filing a "Form 3-F" with the Workers Compensation Court.

Treating Physician (full name)	Address:	City	State	Zip

Employer:	Employer's FEI# (Federal ID Number):	Telephone:

Complete Mailing Address:	City:	State:	Zip:

Complete Street Address (If different from above):	City:	State:	Zip:

Any person receiving temporary disability benefits from an employer or the employer's insurance carrier shall within seven (7) days report in writing to the employer or insurance carrier any change in a material fact or the amount of income the employee is receiving or any change in the employee's employment status, occurring during the period of receipt of such benefits.

Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

CLAIM INFORMATION (Please Print)

Is this a claim for initial benefits (i.e. no benefits, either medical or indemnity, have been received)? ☐ YES ☐ NO

Is this a claim for additional benefits (e.g. additional temporary total disability, additional medical? ☐ YES ☐ NO

List person or entity (with address, phone number) which has paid benefits under a group health, disability or loss of income policy for the injury reported on this form:

—

Name of claimant's attorney if represented:

Type or Print Name of Attorney:	OBA#
RICHARD A. BELL	685
Mailing Address: 3151 W. Tecumseh Rd., Suite 100	
City: NORMAN, State: OK Zip: 73072	
Telephone #: (405) 329-6850	

The undersigned declare under PENALTY OF PERJURY that they have examined this Employee's First Notice of Claim for Compensation, and all statements contained herein are true, correct and complete, to the best of their knowledge and belief.

Signed this 12th day of October, 2017

Robert Shane Rohr by RHB
Signature of Claimant (must be signed by claimant

Richard A. Bell
Signature of Attorney for Claimant (if any)

c. 02/01/14 **ATTORNEY LIEN CLAIMED**
Jeannie Snider
Attorney at Law

P. O. Box 370
Norman OK 73070

SSDI/MEDICARE QUESTIONNAIRE

Claimant's Name: x Robert Shane Zoher

Medicare requires certain information to be obtained on all workers' compensation settlements. Please answer the following questions so that this document can be part of the record being made at the Oklahoma Workers' Compensation Commission on the settlement of your workplace injury(s).

1. Have you ever applied for SSDI (Social Security Disability) benefits? YES (NO)
2. Have you ever received SSDI payments? YES (NO)
3. If you answered yes to #2, provide the starting and ending date of the SSDI benefit payments. Start _____ End _____
4. Are you currently receiving Medicare benefits? YES (NO)
5. If you answered yes to #4, provide the starting and ending date of the Medicare benefits. Start _____ End _____
6. If you answered yes to #4, what is your Medicare HICN number? _____
7. Do you anticipate applying for SSDI benefits within the next 30 months? YES (NO)

x [signature] 5/9/19
Signature Date

[signature] 5-9-19
Witness Date

CC-FORM-100

Send original and 3 copies to:
Workers' Compensation Commission

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

*** Amended ***

THIS SPACE FOR COMMISSION USE ONLY
ORDER FILED
MAY 30 2019
WORKERS' COMPENSATION COMMISSION

In re claim of:

Full Name of Claimant (Injured Employee) Robert "Shane" Rohr
Claimant's Social Security Number (LAST 5 DIGITS ONLY) XXX-X-8-4322
Name of Employer (Respondent) City of Norman
Employer's Insurance Carrier, Permit # for Commission Approved Individual Self-Insured or Own Risk Group Own Risk

CLAIMANT'S APPLICATION AND ORDER FOR DISMISSAL

COMMISSION FILE NO. CM-2017-01333 R
Date of Injury On or About 2/11/2016 (CUM)

The claimant moves to DISMISS the claim noted above as provided in 85A O.S. §108 and Commission Rule 810:10-5-85(c). In support thereof, the claimant states:

YES	NO	Please mark the appropriate YES/NO response to the left of each numbered question.
X		1. Attached hereto is a receipt showing payment of the $140.00 dismissal fee or an executed payment plan approved by the Commission's business office. *(Payment of the fee is required before the dismissal is effective. 85A O.S., §108.)*
X		2. The claimant is represented by counsel.
	X	3. A permanent total disability order, permanent partial disability order, or Joint Petition Settlement has been entered. *(An order of dismissal is allowed at any time before final submission of the case to the Commission for decision. 85A O.S., §108.)*
X		4. This request is for a dismissal with prejudice. *(Before entering an order for dismissal with prejudice, the Commission may require an evidentiary hearing.)*

Note: If a workers' compensation claim is timely filed and then dismissed WITHOUT prejudice, the claim may be refiled within one (1) year from the date the Order of Dismissal Without Prejudice is filed, even if the limitations period has run.

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

I declare under PENALTY OF PERJURY that I have examined all statements contained herein and they are true, correct and complete, to the best of my knowledge and belief.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party(ies) Jeanne Snider, Assistant City Attorney, OBA#19223
Address (Number & Street) P.O. Box 370
City / State / Zip Code Norman, OK 73070

Claimant Robert "Shane" Rohr
Address (Number & Street) 1916 Twintree Drive
City / State / Zip Code Norman, OK 73071
Telephone # of Claimant (405) 889-5722

Signed this 23rd day of May, 2019

Signature of Claimant X
Print or type name of Attorney for Claimant, if any / OBA # Richard A. Bell, 685
Signature of Attorney of Claimant, if any Richard A. Bell

IT IS THEREFORE ORDERED, for good cause shown, that the above captioned claim is dismissed :

X *With Prejudice* *** _____ *Without Prejudice*

The filing of this order does not adjudicate the rights of any health care provider that has provided reasonable and necessary medical care to the claimant for a work related injury.

BY ORDER OF _____
Administrative Law Judge

5-30-19
Date of Order

Revised 4-18-18