# 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 11 day of July, 2019, by and between, Claimant, Chris Koscinski (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: Chris Koscinski v. City of Norman, Oklahoma, CM-2015-06363 K, seeking damages against the Releasee as a result of an alleged accident that occurred on or about July 5, 2015, 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, Chris Koscinski, the sum of Two Thousand Six Hundred Twenty Nine and 00/dollars; ($2,629.00).

(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 July 5, 2015.

**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 July 5, 2015, as more fully set forth in the Form 3 (Attachment 1) filed by the Releasor with the Oklahoma Workers' Compensation Commission, Case No. CM-2015-06363 K.

**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 11 day of July, 2019.

**CHRIS KOSCINSKI**
**RELEASOR**

**READ, RATIFIED & APPROVED BY:**

**ATTORNEY FOR CLAIMANT/RELEASOR**

## ATTESTATION

STATE OF OKLAHOMA )
) SS.
COUNTY OF OK )

On this 11 day of July, 2019, before me, the undersigned notary public in and for said county and state, personally appeared Chris Koscinski, 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.

Christina Kuykendall
Notary Public

My Commission Expires:
11/8/21

CHRISTINA KUYKENDALL
Notary Public
State of Oklahoma
Commission # 17010335 Expires 11/08/21

# Attachment 1

# CC-FORM-3

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

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

THIS SPACE FOR COMMISSION USE ONLY

FILED
SEP 24 2015
8 WORKERS' COMPENSATION COMMISSION

Send original and 4 copies to:
Workers' Compensation Commission

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

Full Name of Claimant (Injured Employee): CHRIS KOSCINSKI

Name of Employer: CITY OF NORMAN

Commission Use Only: OR 10970

## EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

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

COMMISSION FILE NO. 2015-06363K

*(Please type or print)*

| FULL NAME OF EMPLOYEE (Last, First, Middle): | Social Security Number (LAST 4 DIGITS ONLY): | Phone: |
|---|---|---|
| KOSCINSKI, CHRIS JOHN | XXX-XX-8782 | ( ) 405.802.1972 |

| Mailing Address (Include City, State & Zip): | Date of Birth: | Age: | Sex: |
|---|---|---|---|
| 1922 MUIRFIELD ADA, OK 74820 | 4-9-72 | 43 | M |

| Occupation: | Was your employment agreement in Oklahoma? YES ☑ NO ☐ | Avg. Weekly Wage: | Length of Employment: Years 15 Months 11 Date of Hire: 10-18-99 |
|---|---|---|---|
| FIRE FIGHTER | | MAX | |

| Date of Accident/Injury | Injury resulted from: | Time Injury Occurred |
|---|---|---|
| 7-16-15 | Single Incident ☐ Cumulative Trauma ☐ | ☐ AM ☐ PM |

| Describe parts of the body injured or affected | Place of Injury: City/County/State |
|---|---|
| HEART/CARDIOVASCULAR | NORMAN/CLEVELAND/OK |

| What is the nature of the injury or illness: | Describe with details how the injury occurred. Include object or substance which directly injured you: |
|---|---|
| UNKNOWN | FIGHTING A HOUSE FIRE |

| Have you filed a claim for Social Security Disability Insurance Benefits? | Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of 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? NO 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 "CC-Form-3F" with the Workers' Compensation Commission.

| Treating Physician (full name): | Address: | City: | State: | Zip: |
|---|---|---|---|---|
| DR. TIM MEDCALF | 1146 N. HILLS SHOPPING CTR. | ADA, OK | 74820 | |

| Employer: | Employer's FEI # (Federal ID Number): | Telephone: |
|---|---|---|
| CITY OF NORMAN | | |

| Complete Mailing Address: | City: | State: | Zip: |
|---|---|---|---|
| 411 E. MAIN ST. | NORMAN | OK | 73070 |

| Complete Street Address (if different from above): | City: | State: | Zip: |
|---|---|---|---|
| | | | |

**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.**

**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# |
|---|---|
| JEFFREY M. COOPER | 16484 |

| Mailing Address: | | |
|---|---|---|
| 415 NW 11TH ST. | | |
| City | State | Zip |
| OKLAHOMA CITY, OK | | 73103 |

Telephone #: ( 405 ) 218.9200

**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 23RD day of SEPTEMBER, 2015.

Signature of Claimant (Must be signed by Claimant)

Signature of Attorney for Claimant (if any)

Pursuant to Section 810:2-1-10 of the OWCC Rules, by signing above, I authorize Jeffrey M. Cooper, to serve as my "Representative", as defined in 810:2-1-3, to provide services in the workers' compensation matter, including the presentation of evidence as provided in 85A O.S. §71(C)(1)(a)

Created 2-1-14

# CC-FORM-3

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

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

FILED
AUG 16 2018
3 WORKERS' COMPENSATION COMMISSION

Send original and 4 copies to:
Workers' Compensation Commission

| Full Name of Claimant (Injured Employee) |
|---|
| CHRIS KOSCINSKI |
| Name of Employer |
| CITY OF NORMAN |
| Commission Use Only OR # 10970 |

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

## EMPLOYEE'S FIRST NOTICE OF CLAIM FOR COMPENSATION

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COMMISSION FILE NO. CM 2015-06363-K

*(Please type or print)*

| FULL NAME OF EMPLOYEE (Last, First, Middle): | Social Security Number (LAST 4 DIGITS ONLY): | Phone: |
|---|---|---|
| KOSCINSKI, CHRIS JOHN | xxx-xx-8782 | ( ) 405.802.1972 |

| Mailing Address (include City, State & Zip): | Date of Birth: | Age: | Sex: |
|---|---|---|---|
| 1922 MUIRFIELD ADA, OK 74820 | 4-9-72 | 43 | M |

| Occupation: | Was your employment agreement in Oklahoma? | Avg. Weekly Wage: | Length of Employment: Years / Months / Date of Hire: |
|---|---|---|---|
| FIRE FIGHTER | YES ☑ NO ☐ | MAX | 15 / 11 / 10-18-99 |

| Date of Accident/Injury | Injury resulted from: | Time Injury Occurred |
|---|---|---|
| ***7-06-15*** | Single Incident ☐ Cumulative Trauma ☐ | ☐ AM ☐ PM |

| Describe parts of the body injured or affected | Place of Injury: City/County/State |
|---|---|
| HEART/CARDIOVASCULAR | NORMAN/CLEVELAND/OK |

| What is the nature of the Injury or Illness: | Describe with details how the injury occurred. Include object or substance which directly injured you: |
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| UNKNOWN | FIGHTING A HOUSE FIRE |

| Have you filed a claim for Social Security Disability Insurance Benefits? | Are you eligible for Medicare Benefits or will you become eligible for Medicare Benefits within 30 months of the filing of this Notice of 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? NO 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 "CC-Form-3F" with the Workers' Compensation Commission.

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|---|---|---|
| CITY OF NORMAN | | |

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|---|---|---|---|
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Name of claimant's attorney if represented:

| Type or Print Name of Attorney: | OBA# |
|---|---|
| JEFFREY M. COOPER | 16484 |
| Mailing Address: | |
| 415 NW 11TH ST. | |
| City / State / Zip | |
| OKLAHOMA CITY, OK 73103 | |
| Telephone #: | |
| ( 405 ) 218.9200 | |

**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 14TH day of AUGUST, 2018.

Signature of Claimant (Must be signed by Claimant)

Signature of Attorney for Claimant (if any)

Created 2-1-14