Form 113
Designation of Physician
Revised 03-12-03

Two-Sided Form

COMMONWEALTH OF KENTUCKY
OFFICE OF WORKERS' CLAIMS
Claim No. _______________

NOTICE OF DESIGNATED PHYSICIAN

EMPLOYEE: ________________________________
Name

____
Street Address

____
City, State, Zip

(   ) ________
Telephone Number

____
Date of Birth

____
Social Security Number

EMPLOYER AT TIME OF INJURY OR LAST EXPOSURE:

____
Name

____
Street Address

____
City, State, Zip

NATURE OF INJURY OR OCCUPATIONAL DISEASE: ________________________________

____

DATE OF INJURY OR LAST EXPOSURE: ________________________________

FIRST DESIGNATED PHYSICIAN:

____
Name

____
Street Address

____
City, State, Zip

(   ) ________
Telephone Number

Accepted by: ________________________________

MEDICAL INFORMATION RELEASE: I hereby waive any privilege I may have to restrict the release of information or written material reasonably related to the work-related injury/disease for which I have sought treatment, and I consent to the release of this information or written material to the medical payment obligor, my employer, Special Fund, Uninsured Employers' Fund, or attorneys representing me or any of the parties named above.

____
Date

____
Employee Signature

MEDICAL PAYMENT OBLIGOR:

Kentucky League of Cities
Name Of Obligor

____
Representative

PO Box 14880
Street Address

Lexington, KY 40512
City, State, Zip

(800) 382-7729
Telephone Number

This form identifies the designated physician and must be returned to the medical payment obligor within ten (10) days after treatment begins. An identification card will be provided to the employee, and that card should be presented when medical treatment is required.