FORM 105
October 2016 Edition

KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
PLAINTIFF'S CHRONOLOGICAL MEDICAL HISTORY

_____
Plaintiff Name

_____
Claim Number

Include all injuries and major illnesses to the date of filing of the claim
(Begin with most recent treatment)

Name & Address of Physician or Hospital	Date Treatment Received	Nature of Injury or Disease and Part of body affected?	Still under a doctor's care?
1.			
2.			
3.			
4.			
5.			
6.			

I hereby certify that the above information is true and correct to the best of my knowledge and belief.

_____
Plaintiff's Signature Date