

COMMONWEALTH OF KENTUCKY  
OFFICE OF WORKERS' CLAIMS  
Claim No. \_\_\_\_\_

**NOTICE OF SECOND DESIGNATED PHYSICIAN**

EMPLOYEE: \_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip  
\_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

( ) \_\_\_\_\_  
Telephone 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: \_\_\_\_\_

SECOND DESIGNATED PHYSICIAN:  
\_\_\_\_\_  
Name  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip  
Accepted by: \_\_\_\_\_

( ) \_\_\_\_\_  
Telephone Number

**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:  
\_\_\_\_\_  
Name Of Obligor  
\_\_\_\_\_  
Representative  
\_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City, State, Zip

( ) \_\_\_\_\_  
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.**

**Notice:** The Workers' Compensation Act requires the employer to pay for the medical services reasonably necessary for cure and relief from the effe  
lace injury or disease.

The employee may choose the physician (including chiropractors, etc.) who treats him as "designated physician." The designated physician is responsible for the coordination of the employee's medical care and may refer the patient to consulting or treating physicians as required. Except in an emergency, all treatment must be performed by or on referral from the designated physician. The employee may not change his designated physician more than once without the medical payment obligor's consent.

Inquiries shall be made to the listed representative of the medical payment obligor.

This form is not advance authorization from the workers' compensation medical payment obligor for medical services.