Form 105
October 2016 Edition

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

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

Name	Claim Number

Name and Address of Physician or Hospital	Date Treatment Received	Nature of Injury or Disease and Body Part affected	Still under a Doctor's care?
1.			
2.			
3.			
4.			
5.			
6.			
7.			

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

Plaintiff's or Attorney's Signature

Date