Form CMB-MR-2
Medical Report for Continuation of Benefits
Revised August 2018

KENTUCKY LABOR CABINET

Department of Workers' Claims

657 Chamberlin Avenue
Frankfort, KY 40601

MEDICAL REPORT IN SUPPORT OF CONTINUATION OF MEDICAL BENEFITS

WORKERS' COMPENSATION CLAIM NUMBER: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

DATE OF INJURY/LAST EXPOSURE: _____

NATURE OF INJURY/OCCUPATIONAL DISEASE: _____

NAME OF PHYSICIAN ISSUING REPORT: _____

ADDRESS: _____

MEDICAL SPECIALTY: _____

Is it your opinion that continued medical treatment is reasonably necessary for the work injury or occupational disease?

YES_____ NO_____

Explain:

_____
_____

If you answered the previous question "yes" provide a general description of reasonably necessary treatment related to the work injury or disease:

_____
_____
_____

PHYSICIAN: _____

DATE: _____