Crime Victims Compensation Board
500 Mero St., Frankfort, KY 40601
crimevictims@ky.gov
502-782-8255

PHYSICIAN STATEMENT

Complete only if applying for lost wages/ loss of support.
To be completed and signed by PHYSICIAN only.

Victim / Patient Name: ____

Type of Injury: ____

Date of Injury: ___________________________ Date(s) victim/patient unable to work: _________to _________

Victim/Patient suffered permanent disability: ( ) Yes ( ) No

If yes, please state the victim's percentage of permanent disability to the body as a whole in accordance with the AMA Guidelines:
____

Description of injury/trauma resulting from crime and comments:

Name of Physician: _________________________________ Specialty: _________________________________

Office Address: ____
Address City State Zip Code

Telephone: ___________________________________ State License Number: ______________________________

____ __________________________
Physician's Signature Date