CABINET FOR WORKFORCE DEVELOPMENT DEPARTMENT OF VOCATIONAL REHABILITATION

SURGICAL REPORT

Patient Name:

Surgical Procedures:

Hospital Name:

Number of days to be hospitalized:

*Assistant:

*Anesthetist:

Report of Examination:

Vocational Prognosis:

SIGNED: ______M.D.

Mail to:

*Must have name of assistant and/or anesthetist. If that person is an employee of the hospital, the fee for the assistant and/or anesthetist can <u>not</u> be paid.

The Kentucky Department of Vocational Rehabilitation does not discriminate on the basis of race, color, national origin, sex, age, religion or disability.