



**FAX COVER SHEET**

**TO: State Self Insurance Fund**

**FAX: 785-296-6995**

**FROM:**

**PHONE:**

**DATE:**

**NUMBER OF PAGES** (Including Cover sheet)   2  

*COMMENTS:* (to be completed and submitted with written restrictions **immediately after each and every appointment.**)

Claimants name: \_\_\_\_\_

Claimants SS# or claim #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

\_\_\_\_\_ Our agency **WILL** be able to accommodate written restrictions provided by Dr \_\_\_\_\_ beginning \_\_\_\_\_.

\_\_\_\_\_ Our agency will **NOT** be able to accommodate written restrictions provided by Dr \_\_\_\_\_ as of \_\_\_\_\_.

Follow up appointment date/time \_\_\_\_\_ with Dr \_\_\_\_\_.

**\*\*CONFIDENTIAL\*\***

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[www.kdheks.gov/hcf/](http://www.kdheks.gov/hcf/)

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