CONFIDENTIAL MEDICAL INFORMATION

The information submitted on this form is confidential and will not be available for public inspection. Upon request, the State of Ohio will be permitted to view this form.

Name of Defendant___________________________________Case No._________________

1. Name and address of Medical Provider________________________________

   Location of services, if different than above_____________________________

2. Name and address of Medical Provider________________________________

   Location of services, if different than above_____________________________

3. Name and address of Medical Provider________________________________

   Location of services, if different than above_____________________________