WORKERS' COMPENSATION: Pre-Designation of Personal Physician (07)

If your employer offers group health insurance, you are eligible to treatment with your personal physician should you become injured on the job. If you are eligible, **before you are injured**, you must notify your employer **in writing** and provide your employer **written** documentation from your personal physician that they agree to be pre-designated. Your personal physician must be your regular primary care physician who previously directed your medical treatment, who retains your medical history and records. You may only pre-designate your primary care physician if they are a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist, pediatrician or a multi-specialty medical group, whose practice is predominantly for non-occupational injuries and illnesses.

You may use this form to notify your employer of your personal physician. You may choose to use another form as long as you notify your employer, **in writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be pre-designated. Otherwise, you will be treated by one of your employer's designated workers' compensation medical providers.

EMPLOYEE NAME (Please Print): _____

☐ **I acknowledge receipt of this form and elect NOT** to pre-designate my personal physician at this time. I understand that I will receive medical treatment from my employer's medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

☐ **If I am injured on the job, I wish to be treated by my personal physician***:

Name of Physician: _____ Phone: _____

Physician Address: _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Employee Signature: _____ Date: _____

A PERSONAL PHYSICIAN MUST BE WILLING TO BE PRE-DESIGNATED AND TREAT YOU FOR A WORKERS' COMPENSATION INJURY. **THE REMAINDER OF THE FORM IS TO BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO YOUR EMPLOYER.**

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code §4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee does not sign other **written** documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, Section 9780.1(a)(3).

PERSONAL PHYSICIAN NAME: _____

_____ **I agree to treat** the above name employee in the event of an industrial accident or injury. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

_____ **I do NOT agree to treat** the above employee in the event of an industrial accident or injury.

_____ **I do NOT qualify as the employee's personal physician**. I am not a M.D., or D.O., or do not meet the criteria outlined above.

_____ _____

Physician Signature Date

Revised: July 2023