

PERSONAL PHYSICIAN PRE-DESIGNATION FORM

Date employee was provided Pre-Designation Form: _____

Employee: _____

Department: _____

Pursuant to labor Code 4600(d), the definition of "Personal Physician" means:

- ◆ The employee's regular physician and surgeon,
- ◆ Who, prior to the injury, has directed medical treatment of the employee,
and
- ◆ Retains the medical records and medical history of the employee.

Name of Physician: _____

Specialty: _____

Address: _____

Telephone: _____

Employee Name (print):

Employee Signature:

Date of Request:

If this form and the attached Certification is not completed and returned to the Employer prior to an industrial injury, the employee is to seek medical treatment from the Employer-designated medical facility as noted on the posted notices regarding workers' compensation.

Your personal physician is required to adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary Treating Physician and labor Code 4610, Utilization Review. Your personal physician must agree to be your pre-designated physician.

Please have your personal physician sign and return to your Employer the attached Certification acknowledging his/her responsibility as your treating physician should you sustain an industrial injury.

Date: _____

Physician: _____

Employee: _____

CERTIFICATION

This is to certify that _____(employee) is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I am willing to take responsibility for following the rules required of a Treating Physician, per California Code of Regulations, Title 8, Section 9785, when treating this employee for work-related injuries or illnesses. I acknowledge all requests for medical care will be governed by Labor Code 4610, which outlines mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM).

Physician's Signature: _____

Print Name: _____

Date: _____

I decline the request of (employee) to be his/her Treating Physician for work-related injuries.

Physician's Signature: _____

Print Name: _____

Date: _____