PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- ✓ on the date of your work injury you have health coverage for injuries or illnesses that are not work related;
- ✓ the doctor is your regular primary care physician and is either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner; and has previously directed your medical treatment and retains your medical records including your medical history;
- ✓ your personal physician is part of a single corporation or partnership multispecialty medical group composed of licensed doctors of medicine or osteopathy, who provide comprehensive medical services predominantly for non-occupational illnesses and injuries;
- ✓ prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- ✓ prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal M.D. or D.O. treat you for a work- related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee must complete all information in this section.

To: _____ (name of employer),

If I have a work-related injury or illness, I choose to be treated by:

_____M.D./D.O. (name of doctor/group)

_____ (street address, city, state, ZIP)

_____ (telephone number)

Employee name (please print): _____

Employee address: _____

Name of insurance company, plan or fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature: _____ Date: _____

Physician: I agree to this Predesignation.

Signature: _____ Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form. However, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Taken from Title 8, California Code of Regulations, section 9783
Effective February 2014