

Personal Physician Pre-Designation Form

(Workers' Compensation)

You can be treated immediately by your personal medical doctor (MD) or a Doctor of Osteopathy (DO) if the doctor has treated you in the past, has your medical records, and prior to the injury, the doctor agreed to treat you for work injuries or illnesses and you gave your employer the doctor's name and address in writing.

The above describes "pre-designating a personal physician." If you give your employer the name and address of a personal chiropractor (DC) or acupuncturist (LAC) in writing, prior to the injury or illness, your claims administrator will arrange treatment with another doctor, then you may switch to the chiropractor or acupuncturist upon request during the first 30 days after your employer knows of your injury or illness. You can notify your employer by completing the following form and returning it to your department.

EMPLOYEE (complete this section)

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

Physician Name: _____ (circle one: MD, DO, DC, LAC)

Physician Street Address: _____

Physician City, State, ZIP: _____

Physician Phone #: _____

"I understand that this physician must be my regular, primary care physician, must have directed my medical treatment in the past, and must maintain my medical records including my medical history."

Employee Name: _____
(please print)

Employee Signature: _____ Date: _____

(Note to Employee: It is the employee's responsibility for asking the physician to complete and sign the section below)

PHYSICIAN (complete this section)

"I agree to treat the above named individual should s/he have a work injury or illness. I understand that medical services in the California Workers' Compensation system are subject to pre-authorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees governed by the Official Medical Fee Schedule promulgated by the Division of Workers' Compensation."

Physician Name (please print): _____

Physician Signature: _____

Office Manager/Billing Contact Name(s): _____

Street Address: _____

Mailing Address (if different): _____

Telephone: _____ Fax: _____

Email: _____ Physician Tax ID #: _____

Employee must return completed and signed form to his/her department

Privacy Notice

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves:

The principal purpose for requesting the information on this form is to provide the employee with a means to notify the University in writing, prior to the occurrence of a work-related injury or illness, of the employee's wish to designate a personal physician to render medical treatment immediately following a work-related injury or illness, and to designate such physician.

Furnishing all information on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being completed. The information provided may be released pursuant to applicable Federal and State law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements.

This completed Personal Physician Pre-Designation form will be kept in the employee's departmental payroll file.