PRE-DESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury of 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 care coverage for inquires or illnesses that are not work related;
- The doctor is your regular physician, who shall be 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 medical treatment, and retain your medical records;
- Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational 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.

Employee Name: _____ **Unit:** _____

☐ **I acknowledge receipt of this form and elect not to predesignate 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.

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

Name of Physician: _____ Phone #: _____

Physician Address: _____

Employee Signature: _____ **Date:** _____

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

PERSONAL PHYSICIAN NAME: _____

I agree to treat the above employee in the event of an industrial injury or illness. I further certify that I am the employee's regular primary care physician, have previously directed employee's medical treatment and retain their medical records including medical history.

Physician Signature: _____ **Date:** _____

(Rev. March 2020)