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 District's Risk Management office prior to an industrial injury, the employee is to seek medical treatment from District's 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. Your personal physician must agree to be your pre-designated physician and that they will accept payment for service in accordance with the California Official Medical Fee Schedule.

Please have your personal physician sign and return this form to the District's Risk Management office with the Certification acknowledging their responsibility as your treating physician should you sustain an industrial injury.

CERTIFICATION

This is to certify that (employee name) _____ 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 rules required of the 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 outlining 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 _____ to be his/her Treating Physician for work-related injuries.

Physician's Signature: _____

Print Name: _____

Date: _____

Please return this form to:

Orange Unified School District
Risk Management Department
1401 N. Handy Street
Orange, CA 92867