Shasta College

HUMAN RESOURCES OFFICE

11555 Old Oregon Trail, Redding, CA 96003
Telephone: (530) 242-7640

workers' compensation: Pre-Designation of Personal Physician

If your employer offers group health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 to qualify as the your predesignated, personal physician, the physician must agree, in writing, to treat you for a work related injury, must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist, pediatrician or a multi-specialty medical group, whose practice is predominantly for non-occupational injuries or illnesses. If you do not have a predesignated physician, you will be treated by one of your employers' designed workers' compensation medical providers. You may choose to predesignate a physician at any time prior to being inured on the job.

EMPLOYEE NAME: _____

❑ 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 employers' 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.

Employee Signature: _____ Date: _____

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

Name of Physician _____ Phone Number _____

Physician Address _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Employee Signature: _____ Date: _____

A *Personal Physician* must be willing to be predesignated and treat you for a workers' compensation injury.
The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other written documentation of the physicians' agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN NAME: _____

❑ *I agree to treat* the above named employee in the event of an industrial accident or injury. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

❑ *I do not agree* to treat the above employee in the event of an industrial accident or injury.

❑ *I do not qualify* as the employees' personal physician. I am not an M.D. or D.O. or do not meet the criteria outlined above.

_____ _____
Physician Signature Date

Please return completed form to:

Shasta College Human Resources * fax number 530-225-4990