San Bernardino Community College District

OFFICE OF HUMAN RESOURCES
114 S. DEL ROSA DRIVE; SAN BERNARDINO CA 92408
PHONE 909-382-4040 FAX 909-382-0173

AUTHORIZATION FOR MEDICAL TREATMENT

WORK-RELATED EMPLOYEE INJURY

EMPLOYEE PERSONAL INFORMATION

EMPLOYEE NAME: ____________________ EMPLOYMENT SITE: ____________________

DATE OF INJURY: ____________________ TIME OF INJURY: __________ ☐ AM ☐ PM

WORKING DAYS: ____________________ WORKING HOURS: ____________________

JOB TITLE: ____

IMPORTANT - CHOOSE ONE OPTION LISTED BELOW:

☐ **I ACCEPT** MEDICAL TREATMENT AT A CLINIC DESIGNATED BY THE SAN BERNARDINO COMMUNITY COLLEGE DISTRICT AS LISTED BELOW. *PLEASE SELECT ONE OF THE CLINICS BELOW BY CHECKING THE APPROPRIATE BOX.*

☐ **I DECLINE** MEDICAL TREATMENT AT THIS TIME. ADDITIONALLY, I UNDERSTAND THAT IF I SHOULD NEED MEDICAL TREATMENT AT A LATER DATE I WILL NOTIFY MY SUPERVISOR AND HUMAN RESOURCES.

☐ I CHOOSE TO BE TREATED BY THE **PRE-DESIGNATED PHYSICIAN**. I UNDERSTAND THAT THIS PHYSICIAN SIGNED DESIGNATION MUST BE ON FILE WITH HUMAN RESOURCES ***PRIOR*** TO THE DATE OF THIS INJURY AND THAT PHYSICIAN I HAVE CHOSEN HAS PREVIOUSLY TREATED ME, HAS MY MEDICAL RECORDS, AND HAS AGREED TO TREAT ME IN THE EVENT OF A WORK-RELATED INCIDENT..

NOTE: USE OF AN UNAUTHORIZED MEDICAL FACILITY MAY RESULT IN NON-PAYMENT OF THE BILL.

√	NAME	ADDRESS (MAP ON BACK SIDE)	PHONE	HOURS
☐	COMP – CENTRAL OCCUPATIONAL MEDICINE PROVIDERS	295 E. CAROLINE ST., STE D1 SAN BERNARDINO, CA 92408 **OTHER LOCATIONS AVAILABLE**	909-723-1161	24 HOURS 7 DAYS/WEEK
☐	FOX OCCUPATIONAL MEDICAL CENTER	1375 CAMINO REAL, STE 130 SAN BERNARDINO, CA 92408	909-884-1500	8:00 AM TO 5:00 PM MON-FRI

I HAVE BEEN GIVEN THE FOLLOWING FORMS:

1. State Claim Form DWC – 1
2. Employee Statement
3. Instructions for Injured Workers
4. Covered Employee Notification of Rights Materials (MPN)

EMPLOYEE SIGNATURE: ____________________ DATE: __________

AUTHORIZED SUPERVISOR (PRINT): ____________________ TITLE: __________

SUPERVISOR SIGNATURE: ____________________ DATE: __________

INSTRUCTIONS TO MEDICAL PROVIDER:
MAIL ORIGINAL DOCTOR'S FIRST REPORT AND ALL MEDICAL BILLS TO:

FIRST AID CLAIMS ONLY:
SBCCD, ATTN: HUMAN RESOURCES
114 S. DEL ROSA DR.
SAN BERNARDINO, CA 92408

RECORDABLE CLAIMS:
KEENAN & ASSOCIATES
PO BOX 59916
RIVERSIDE, CA 92517

951-715-0190
KIMBERLY WISER, EXT 1190
951-788-8013 (FAX)

DISTRIBUTION: ***ORIGINAL: MEDICAL PROVIDER*** ***(IF DECLINING TREATMENT –SEND TO HR)*** ***COPY: FAX TO SBCCD HR 909-382-0173*** ***COPY: EMPLOYEE***