SAN BERNARDINO COMMUNITY COLLEGE DISTRICT
Office of Human Resources and Employee Relations

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.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer in writing prior to being injured on the job and provide written verification that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated worker's compensation medical providers.

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 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.

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 worker's 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 physician's 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:

San Bernardino Community College District, 550 E. Hospitality Lane, St 200, San Bernardino, CA 92408
Attention: Office of Human Resources Fax: 909-387-1103

CC: Personnel File