EL CAMINO COMMUNITY COLLEGE DISTRICT
Workers' Compensation: Pre-Designation of Personal Physician Election Form

If you have 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), or medical group, if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as 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 or pediatrician. Your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors or medicine or osteopathy, which operates an integrated multi-specialty medical group providing comprehensive medical services predominantly for non-occupational illnesses and injuries.

This is an optional form that can be used to notify your employer of your personal physician. The physician or medical group must agree to be predesignated, and in advance of any injury. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE/VOCATIONAL STUDENT'S NAME & ADDRESS: _____

_____

❑ **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/Vocational Student Signature: _____ Date: _____

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

Name of Physician or Medical Group _____ Phone Number _____

Address _____

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

Name of Insurance Company, Plan, or Fund providing health coverage for non-occupational injuries or illnesses:

_____

Employee/Vocational Student 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 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 OR MEDICAL GROUP 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.

_____ _____
(Physician/or Designated Employee of the Physician/or Medical Group) Date

Form Distribution: 1) Office of Workplace Safety & Risk Management; & 2) Employee's Personnel File/or Vocational Student's File

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