BURBANK UNIFIED SCHOOL DISTRICT
HUMAN RESOURCE SERVICES
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PLEASE RETURN COMPLETED FORM TO HUMAN RESOURCES

- ALL PRE-DESIGNATION FORMS SUBMITTED PRIOR TO 8/15/06 ARE NO LONGER VALID -

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 (MD, DO) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600, **to qualify as your pre-designated, 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 pre-designated physician must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

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 pre-designated. Otherwise, you will be treated by one of your employer's designated Workers' Compensation medical providers.

Employee Name: _____ **Work Site:**_____
Last Name First Name MI

☐ I acknowledge receipt of this form and elect not to pre-designate 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, per Labor Code 4600*.

Name of Physician:_____ Phone Number:_____

Street Address:_____

City: _____ State:_____ Zip Code:_____

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

Employee Signature:_____ Date:_____

Personal Physician Acknowledgement

The remainder of this form is to be completed by your physician and returned to your Employer.

Per Labor Code 4600, to qualify, a personal physician must meet the criteria outlined above. You are not required to sign this form, however, if you or your designee, do not sign, other written documentation of the physician's agreement to be pre-designated 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 am the employee's personal physician (MD or DO) who has previously directed his/her medical care and retain his/her medical history and records.
☐ **I do not agree** to treat the above named employee in the event of an industrial accident or injury.
☐ **I do not qualify** as the employee's personal physician. I am not an MD or DO or, do not meet the criteria outlined above.

Physician Signature:_____ Date:_____