HARTNELL COLLEGE

Print Form

Reset Form

workers' compensation: Pre-Designation of Personal Physician

If you have health insurance and 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 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. The 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 of 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. 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.

If you do not provide advance written notification, verification, and agreement of your pre-designated personal physician, you will be treated by one of the District's designated workers' compensation medical providers.

EMPLOYEE NAME: _____ LAST FOUR DIGITS OF SSN: _____

I acknowledge receipt of this form and do not elect to pre-designate 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: _____

I elect to pre-designate that if I am injured on the job, I want 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.*

Employee Signature: _____ Date: _____

*A *Personal Physician* must be willing to be pre-designated to treat you for a workers' compensation injury.
The remainder of this form is to be completed by your pre-designated 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 it, other written documentation of the physicians' agreement to be pre-designated 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.
- ❑ 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 I do not meet the criteria outlined above.

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

Completed form must be returned to:
Hartnell College, Human Resources Department
Fax: 831.755.6937