Employee's Pre-designation of Personal Physician

(California Code of Regulations 9780.1)

In the event that I suffer an on-the-job illness/injury, I wish to be treated by the personal physician designated below. This pre-designation is only valid if signed by the physician and the original submitted to Risk Management, Room 421 in advance of an injury. The physician I have named meets the minimum requirements pursuant to the following definition:

Labor Code Section 4600 defines a personal physician as my regular physician and surgeon (a doctor of medicine (MD) or a doctor of osteopathy (DO) licensed pursuant to the Business and Professions Code, Section 2000), who has previously directed my medical treatment and who retains my medical records, including my medical history and who has agreed in advance to the terms and conditions of pre-designation as noted below.

If I seek medical care for an illness/injury that I believe to be work-related, I will immediately inform my supervisor, who will provide me form DWC-1: *Employee's Claim for Workers' Compensation Benefits*. I will notify my physician that I was injured on the job.

Physician _____

Address _____

_____

Phone _____ **Fax** _____

_____ _____ _____

Employee Name (type/print) **Department** **Last 4 digits of Soc Sec #**

_____ _____

Employee Signature **Date**

TO PRE-DESIGNATED PHYSICIAN ONLY:

The employee identified above has chosen you as the pre-designated physician for medical treatment in the event of a Workers' Compensation injury or illness. To qualify as a pre-designated physician you must have previously directed the employee's medical care and currently retain his/her medical records. In addition, effective 4/19/04 the law requires that you agree in advance to be this employee's pre-designated physician.

Your signature below confirms that you:

- Qualify as a pre-designated physician pursuant to the above criteria
- Agree to be pre-designated by this individual
- Accept the Workers' Compensation Official Medical Fee Schedule and be subject to utilization review according to the ACOEM Guidelines and any rules/regulations promulgated by the Administrative Director, Self-Insurance Plans, State of California.

Please sign, date and FAX this form to **Risk Management Division, County of Marin @ 415- 499-3729 to validate this pre-designation request.**

_____ _____

Physician Signature **Date**

TAX ID # _____

Original: Risk Management Copy 1: Department Personnel File Copy 2: Human Resources