Shawn Judson, Ed.D.
Superintendent
Douglas M. Claflin
Assistant Superintendent of Business Services
Terry Embleton
Assistant Superintendent of Personnel Services
Charlayne Sprague
Assistant Superintendent of Instruction/Pupil Services

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PERSONAL PHYSICIAN PRE-DESIGNATION FORM

Date employee was provided Pre-Designation form: _____

Employee: _____ / _____
Please Print Work Location

Pursuant to Labor Code 4600(d), the definition of "Personal Physician" means:

- √ The employee's regular physician and surgeon,
- √ Licensed pursuant to Chapter 5, Division2, beginning with Section 2 of the Business and Professions Code (which, by the way, partly states that the physician is licensed to provide drugs, use devises, penetrate human tissue, sever human tissue)
- √ Who, prior to the injury, has been the employee's primary care physician and has previously directed the medical treatment of the employee **AND**, and
- √ Who retains the employee's medical records and medical history
- √ It may include a medical group

Name of Physician: _____

Specialty: _____

Address: _____

_____

Telephone: _____

Employee Name (print): _____

Employee Signature: _____

Date of Request: _____

If this form and the attached Certification is not completed and returned to your Employer prior to an industrial injury, the employee is to seek medical treatment from the Employer-designated medical facility as noted on the posted notices regarding workers' compensation.

Your personal physician is required to adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary Treating Physician, and Labor Code 4610. Your personal physician *must agree* to be your pre-designated physician and that they will accept payment for service in accordance with the California Official Medical Fee Schedule.

Please have your personal physician sign this form. It will be the employee's responsibility to ensure that this form is completed and returned to the Etiwanda School District Risk Administration Division. By signing this form, the physician is acknowledging their responsibility as your treating physician should you sustain an industrial injury or illness.

CERTIFICATION

This is to certify that (employee) is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I **am willing** to take responsibility for following rules required of a Treating Physician, per California Code of Regulations, Title 8, Section 9785, when treating this employee for work-related injuries or illnesses. I acknowledge that all requests for medical care will be governed by Labor Code 4610 outlining mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM).

Physician's Signature: _____

Print Name: _____

Date: _____

I **decline** the request of (employee) to be his/her Treating Physician for work-related injuries or illnesses.

Physician's Signature: _____

Print Name: _____

Date: _____

Received by: _____
Risk Services

Date: _____