

GLENDALE UNIFIED SCHOOL DISTRICT

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 if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as the your predesignated, personal physician, the physician must agree to treat you for a work related injury,** must have previously directed your medical care, must retain your medical history and records.

This is an optional form that can be used to notify your employer and 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 verify that your personal physician will treat you for a workers' compensation injury. Otherwise, you will be treated by one of your employer's designated workers' compensation medical providers.

EMPLOYEE NAME: _____

- 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 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*:**

Name of Physician _____ Phone Number _____

Physician Address _____

*This physician is my personal 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 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 agree to be designated as the employee's personal physician and treat this employee for a work related injury.** You must have previously directed the employees medical care and retain their medical history and records. Our primary goal is to provide our employees with prompt, effective, quality medical treatment in the event of an industrial injury. We request your partnership by completing this acknowledgement form.

PERSONAL PHYSICIAN NAME: _____

- I agree to treat the above named employee in the event of an industrial accident or injury.** I have previously directed the employee's medical treatment and retain medical records and medical history. 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 employee's personal physician** per Labor Code 4600. I have not previously directed the employee's medical treatment and do not retain medical records and medical history.

Physician Signature

Date

**Please return completed form to: Human Resources Office, Room 403
Glendale Unified School District – 223 N. Jackson St. Glendale, CA 91206
Tel: (818) 241-3111 x 231**