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Workers' Compensation Pre-Designation of Personal Physician

Rancho Santiago Community College District
Risk Management Services
2323 North Broadway, Suite 225, Santa Ana, California 92706
714-480-7570 Fax 714-796-3918

Dear Employee,

If you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O) if you notify Risk Management, in writing, prior to the injury. **Your personal physician *must also agree* to be your pre-designated physician and that they will accept payment for service in accordance with the California Official Medical Fee Schedule.** Per Labor Code 4600 to qualify as your pre-designated, personal physician, he/she 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.

If you choose not to pre-designate your personal physician, you will receive medical treatment from the District's medical provider in the event you suffer a work-related injury. You may, at any time in the future, change your mind and provide written notification of your personal physician to Risk Management. This written notification must be on file prior to an industrial injury.

EMPLOYEE NAME: _____

If I am injured on the job, I wish to be treated by my personal physician*:

- Name of Physician: _____ Specialty _____
- Address: _____ City_____ Zip_____
- Telephone: _____ Fax #_____

*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 pre-designated and treat you for a worker's compensation injury. ***The remainder of this form is to be completed by your physician and returned to your Employer.***

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

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 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 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.)

☐ ***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 do not meet the criteria outlined above.

_____ _____
Physician Signature Date