

DESIGNATION OF PHYSICIAN FORM

(Workers' Compensation)

You can be treated immediately by your personal medical doctor (M.D.) or a doctor of osteopathy (D.O.) if the doctor has treated you in the past, has your medical records, and prior to the injury, the doctor agreed to treat you for work injuries or illnesses and you gave your employer the doctor's name and address in writing.

The above describes "pre-designating a personal physician." If you give your employer the name and address of a personal chiropractor (D.C.) or acupuncturist (L.A.C.) in writing, prior to the injury or illness, your claims administrator will arrange initial treatment with another doctor, then you may switch to the chiropractor or acupuncturist upon request during the first 30 days after your employer knows of your injury or illness. You can notify your employer by completing the following form and returning it to your employer.

EMPLOYEE (Complete this Section)

If I have a work-related injury or illness, I choose to be treated by:

Physician Name: _____ (circle one: MD, DO, DC, and LAC)

Physician Street Address: _____

Physician City, State, ZIP: _____

Physician Telephone: _____

I understand that this doctor must have treated me in the past and must maintain my medical records.

Employee Name: _____ Employee ID#: _____

Employee Signature: _____ Date: _____

(Note to Employee: It is the employee's responsibility for asking the physician to complete and sign the section below)

PHYSICIAN (Complete this Section)

"I agree to treat the above-named individual should s/he have a work injury or illness. I understand that medical services in the California workers' compensation system are subject to preauthorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees governed by the Official Medical Fee Schedule promulgated by the State Division of Workers' Compensation."

Physician Name (please print): _____

Physician Signature: _____

Street Address: _____

Mailing Address (if different): _____

Telephone: _____ Fax: _____

Email: _____ Physician Tax ID#: _____

Employee must return completed and signed form to the: Workers Compensation Office
9500 Gilman Drive, Mail Code 0925
La Jolla, CA 92093-0925