PASO ROBLES
JOINT UNIFIED SCHOOL DISTRICT
THE DISTRICT OF EXCELLENCE

SUPERINTENDENT: CURT DUBOST
800 NIBLICK ROAD
PASO ROBLES, CA 93446
Tel: (805) 769-1000 Fax: (805) 237-3339
WWW.PASOSCHOOLS.ORG

PRE-INJURY PERSONAL PHYSICIAN PRE-DESIGNATION FOR WORK RELATED INJURIES

Date employee was provided Pre-Designation Form: _____

Employee Name: _____

Employee Address: _____

City, State and ZIP Code: _____

Employer Name: _____

Employer Address and Department: _____

Private Health Insurance Co: _____ Group #: _____

Address: _____

Phone Number: _____

I understand the Worker's Compensation Laws of the State of California indicate that if I have notified my employer in writing prior to the date of injury that I have a personal physician, I shall have the right to be treated by such physician from the date of injury. As defined by law, a "personal physician" must be the employee's regular physician and/or surgeon who has your medical record file and history; must be the employee's primary care physician who has previously directed the medical treatment; must be a medical doctor and not a chiropractor or acupuncturist; must be a part of the employer's non-occupation group coverage and MUST agree to be pre-designated AND comply with workers' compensation laws and reporting requirements. If I am injured on the job, I would like to be treated by the physician whose information is provided below. I verify by signing below that the named physician meets the above legal requirements.

I understand that my employer requires me to contact the named physician who must sign the attached form to prove he/she agrees to treat me in the event of an injury on the job and also prove he/she will abide and adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary treating Physician and Labor Code 4610. I further understand that I am responsible for signing the below document and seeking agreement and signature of the attached document from my personal e

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physician and I am to return all of the documents to my employer. If not all of these steps occur, I am aware my pre-designation form is invalid. If my employer does not have the completed form prior to industrial injury, I will seek medical treatment with the employer's designated medical facility as noted on the posted notices regarding workers' compensation.

Even though I am designating a personal physician, I understand that my employer may require me to undergo medical examinations by other physicians at their request and expense.

Physicians Name: _____

Physicians Address: _____

City, State and ZIP Code: _____

Phone Number: _____

Medical Specialty: _____

I understand that the filing of this form does not relieve me from my obligation to report all injuries immediately to my supervisor and to complete all required reporting forms. I certify that all of the above statements are true and correct to the best of my knowledge.

Employee Signature: _____

Employee Name (print): _____

Date of request: _____

This form must be signed by you AND your personal physician.

You must return ALL of the signed documents to the Human Resources Department BEFORE an injury occurs, to be valid.

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RE: Workers' Compensation medical treatment certification

Dear Dr. _____;

The employee listed on the first page of this document has selected you as a pre-designated physician for work related injuries. For you convenience, the employer has provided a copy of the regulations required of a primary treating physician for treating a patient who is industrially injured. As such, please verify the following information.

CERTIFICATION OF PHYSICIAN

This is to certify I am the above patient's regular, primary care physician. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I have read and agree with the Reporting Duties of the Primary treating Physician, per California Code of Regulations, Title 8, Section 9785 that is attached to this document and agree to abide by the laws 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).

In addition, I agree to accept payment for medical treatment services provided in accordance with the California Official Medical Fee Schedule.

Physician's Signature: _____

Physician's Name (print): _____

Date: _____

OR

I decline the request to be his/her treating physician for work related injuries.

Physician's Signature: _____

Physician's Name (print): _____

Date:_____