***WORKERS' COMPENSATION***
***Pre-Designated Physician Form***

*This Section to be completed by EMPLOYEE:*

Date: _____

Employee Name:_____ Position:_____

In the event of any on-the-job work-related injury, I request that I be treated by my personal physician as indicated below:

Personal Physician: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

**Important Requirements for Personal Physician:**

- The physician is the employee's regular physician (MD), licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
- The physician is the employee's primary care physician under their medical plan and has previously directed the medical treatment of the employee, and retains the employee's medical records, including his/her medical history.
- The physician agrees to be pre-designated and has signed approval below:

**Employee Signature:**_____ **Date:**_____

*This Section to be completed by PERSONAL PHYSICIAN:*

___I agree to be the Pre-Designated Physician for the above-referenced individual for the treatment of work-related injuries**. 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 understand that payment will be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1 of the Labor Code in effect on the date of service. Payments shall be made by the employer within 45 working days after receipt of each separate itemization of medical services provided, together with any reports and any written authorization for services that may have been received by the physician.

___ I decline to be the Pre-Designated Physician for the above-referenced individual for the treatment of work-related injuries.

**Physician's Signature:**_____ **Date:**_____