El Monte Union High School District

Personal Physician Pre-Designation Form

Date Employee was provided Pre-Designation form: _____

Employee: _____ Site: _____

Pursuant to Labor code 4600(d), the definition of "Personal Physician" means:

- The employee's regular physician and surgeon,
- who prior to the injury, has directed medical treatment of the employee, and
- retains the medical records and medical history of the employee

Name of Physician: _____

Specialty: _____

Address: _____

_____

Telephone: _____

Employee Name (print): _____

Employee Signature: _____

Date of Request: _____

If this form and the attached Certification is not completed and returned to your employer prior to an industrial injury, the employee is to seek medical treatment from the employer-designation medical facility as noted on the posted notices regarding workers' compensation.

Your personal physician is required to adhere to Title 8, California Code of Regulations 9785, the Reporting Duties of the Primary Treating Physician and Labor Code 4610. Your personal physician **must agree** to be your pre-designated physician and that they accept payment for service in accordance with the Caledonia Official Medical Fee Schedule.

Please have your personal physician sign and return this form to your employer with the Certification on the back of this form acknowledging their responsibility as your treating physician should you sustain an industrial injury.

Notice to Physician:

This employer has an MPN (Medical Provider Network) in effect. Any referrals to specialist for consultation, treatment, or testing must be made to a provider within the MPN.

CERTIFICATION

This is to certify that (employee) is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

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).

Physician's Signature: _____

Print Name: _____

Date: _____

I decline the request of (employee) to be his/her treating physician for work-related injuries.

Physician's Signature: _____

Print Name: _____

Date: _____