PERSONAL PHYSICIAN PRE-DESIGNATION FORM

Employee: ____

School / Work 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-designated 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 will accept payment for service in accordance with the California Official Medical Fee Schedule.

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

Santa Monica-Malibu Unified School District
1651 16th Street, Santa Monica, CA 90404 • 310.450.8338

Physician Certification

Date: ____________________

Physician Name: ____________________________________

Employee Name: ____________________________________

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 Signed: ____________________________

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

Physician's Signature:____

Print Name: ____

Date Signed: ____________________________

Please return to:

The requesting employee

or

SMMUSD
Attn: Risk Management Office
1651 16th Street
Santa Monica, CA 90404