(B-0006 rev. 7-04)

PREDESIGNATION OF PHYSICIAN FORM

In the event of a work related injury or illness, I request to be treated by my personal physician. I understand this designation must be made prior to the date of injury.

The physician I selected meets the following criteria.

- Within a reasonable geographical area from my residence or work location.
- A Licensed Physician to Chapter 5 of Division 2 of the Business and Professions Code.
- Previously directed my treatment and is my regular physician.
- Retains my treatment records including my medical history.
- Agrees prior to the injury to be designated as my physician in the event an industrial injury occurs.

If my personal physician is not qualified to treat the injury or declines to provide treatment my employer will direct my treatment to an appropriate physician.

My personal physician must review and sign the enclosed criteria from with me submitting both completed forms prior to any date of injury in order for this pre-designation to be valid.

(Please print clearly)

Employee Name: _____ Social Security Number: _____

Pre-designated Physician's Name: _____

Adress: _____

Telephone Number: _____

Employee Signature: _____Date:_____

Employer Signature: _____ Date: _____

- LC Section 4600 (d) If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury if the physician is the employee's regular physician and surgeon, licensed pursuant to Chapter 5 Division 2 of the Business and Professions Code. The physician is the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history. The physician needs to agree to be pre-designated

PHYSICIAN'S AGREEMENT TO CRITERIA FOR PREDESIGNATION

1) I am a physician who is licensed pursuant to Chapter 5 of Division 2 of the Business and Professions Code.
2) I have previously directed medical treatment of the employee and am his/her regular physician.
3) I retain the employee's medical treatment records, including his or her medical history.
4) I agree to treat this employee for a work related injury.
5) I have signed this agreement prior to the employee sustaining an industrial injury.
6) I understand my reporting requirements outlined by Rules and Regulations 9785 through 9785.5
7) I understand that per LC 4604.5 and LC 4610 that my treatment requests will be reviewed by a Utilization Review Department to determine medical necessity in accordance with the American College or Occupational and Environmental Medicine. Further this guideline can be utilized to approve, modify, delay or deny my medical treatment request.
8) I acknowledge the application of the Official Medical Fee Schedule to my charges relating to medical treatment for this work related injury.

I, _____ am a physician and I have read and

certify that I meet and will adhere to the requirements listed above as the pre-designated

personal physician for _____.

Physician's Signature_____Date:_____