

Physician Signature:\_

## BURBANK UNIFIED SCHOOL DISTRICT HUMAN RESOURCE SERVICES

1900 WEST OLIVE AVENUE • BURBANK • CALIFORNIA • 91506 TELEPHONE (818) 729-4416 • FAX (818) 729-4554

PLEASE RETURN
COMPLETED FORM TO
HUMAN RESOURCES

Date:

## - ALL PRE-DESIGNATION FORMS SUBMITTED PRIOR TO 8/15/06 ARE NO LONGER VALID -

## Workers' Compensation: Pre-Designation of Personal Physician

If your employer offers group health insurance and you are injured on the job, <u>you have the right to be treated immediately by your personal physician (MD, DO) if you notify your employer, in writing, prior to the injury.</u> Per Labor Code 4600, **to qualify as your pre-designated, personal physician, the physician must agree**, <u>in writing</u>, to treat you for a work-related injury, must have previously directed your medical care, and must retain your medical history and records. Your pre-designated physician must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer in writing prior to being injured on the job and provide written verification that your personal physician meets the above requirements and agrees to be pre-designated. Otherwise, you will be treated by one of your employer's designated Workers' Compensation medical providers.

Employee Name:		Work Site:		
	Last Name	First Name	MI	
will receive medical treatment change my mind and proving the change my manufactured my manufactured my my mind and my manufactured my manufactured my my my my manufactured my	nent from my em ide written notifi	ployer's medical provid	ler. I understand	that, at any time in the future, I can
Employee Signature:				Date:
If I am injured on the job,	wish to be treat	ted by my personal phy	sician, per Labor	Code 4600*.
Name of Physician: Phone Number:				
Street Address:				
City:			State:	Zip Code:
*This physician is my person	al physician and h	as previously directed my	medical care and i	retains my medical history and records.
Employee Signature:				Date:
	Pers	onal Physician Ac	knowledgem	ent
The remainder	of this form is t	to be completed by yo	ur physician an	d returned to your Employer.
m, however, if you or your o	lesignee, do not	sign, other written doc	umentation of the	physician's agreement to be pre-
rsonal Physician Nar	ne:			
above. I agree to adhere employee-designated phy medical care and retain hi I do not agree to treat the	to the Administra sician. I am the s/her medical his above named e	ative Director's Rules a employee's personal p story and records. employee in the event of	nd Regulations, S hysician (MD or I of an industrial acc	Section 9785, regarding the duties of the DO) who has previously directed his/her cident or injury.
	I acknowledge receipt of the will receive medical treatme change my mind and provide on file prior to an industation of the prior to an industrial o	I acknowledge receipt of this form and ele will receive medical treatment from my em change my mind and provide written notifi be on file prior to an industrial injury.  Employee Signature:  If I am injured on the job, I wish to be treat Name of Physician:  Street Address:  City:  *This physician is my personal physician and he Employee Signature:  Pers  The remainder of this form is the signated will be required pursuant to Title 8 personal Physician Name:  I agree to treat the above named employ above. I agree to adhere to the Administration employee-designated physician. I am the medical care and retain his/her medical hid not agree to treat the above named employen agree to treat the above named employen to treat the above named employer th	I acknowledge receipt of this form and elect not to pre-designate will receive medical treatment from my employer's medical provice change my mind and provide written notification of my personal post on file prior to an industrial injury.  Employee Signature:  If I am injured on the job, I wish to be treated by my personal phy Name of Physician:  Street Address:  City:  *This physician is my personal physician and has previously directed my Employee Signature:  Personal Physician Active The remainder of this form is to be completed by your Labor Code 4600, to qualify, a personal physician must meet the m, however, if you or your designee, do not sign, other written docisignated will be required pursuant to Title 8, California Code of Registrated Physician Name:  I agree to treat the above named employee in the event of an incomposition above. I agree to adhere to the Administrative Director's Rules a employee-designated physician. I am the employee's personal pmedical care and retain his/her medical history and records.  I do not agree to treat the above named employee in the event of an incomposition of the second process.	I acknowledge receipt of this form and elect not to pre-designate my personal phy will receive medical treatment from my employer's medical provider. I understand change my mind and provide written notification of my personal physician. I understand be on file prior to an industrial injury.  Employee Signature:  If I am injured on the job, I wish to be treated by my personal physician, per Labor Name of Physician:  Petreet Address:  City:  *This physician is my personal physician and has previously directed my medical care and Employee Signature:  Personal Physician Acknowledgem  The remainder of this form is to be completed by your physician and the provided my medical care and the p