

## PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

### NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN: (Employee: Complete this section)

To (name of Employer): \_\_\_\_\_

If I have a work-related injury or illness, I choose to be treated by:

(name of doctor,

M.D., D.O., or medical group)

(street address, city, state, ZIP) \_\_\_\_\_

Employee Name (please print): \_\_\_\_\_

Employee address: \_\_\_\_\_

Name of Insurance Company,  
Plan, or Fund providing health  
coverage for nonoccupational  
injuries or illnesses: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### PHYSICIAN: I AGREE TO THIS PREDESIGNATION:

(Physician or Designated Employee of the Physician or Medical Group)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

## NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

### YOUR CHIROPRACTOR OR ACUPUNCTURIST'S INFORMATION:

Name of chiropractor or  
acupuncturist: \_\_\_\_\_

Street address, city,  
state, zip code: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Employee Name (please print): \_\_\_\_\_

Employee address: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_

Date: \_\_\_\_\_