CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP
550 ELLINWOOD WAY - PLEASANT HILL CA 94523
1.866.922.2744 - FAX 925.692.1137

STATEMENT OF PERSONAL PHYSICIAN DESIGNATION AND PRE-DESIGNATED PHYSICIAN FORM

TO _____ DISTRICT _____

FROM _____ _____
Social Security Number

_____ _____
Work Site Position/Classification

I hereby request that I be treated by my personal physician (M.D.) or a doctor of osteopathic medicine (D.O.) in the event of any work-related injury. I understand that this designation must be made prior to the date of injury and is valid only if my employer offers group health coverage. If the name of a chiropractor (D.C.) or acupuncturist (L.AC.) is submitted in writing prior to an injury, my employer will arrange treatment with another medical doctor. Further:

- The doctor is my 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 my medical treatment, and retains my medical records

_____ (____)_____
Physician's Name (M.D., D.O.) Phone Number

_____
Name of Medical/Physician's Business and Address

TO BE COMPLETED BY PHYSICIAN:

I have directed the medical treatment for _____
Employee's Name
in the past and retain the medical records and medical history for this individual.

The Physician is not required to sign this form; however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be pre-designated will be required pursuant to title 8. California Code of Regulations, section 9780.1(a)(s).

_____ _____
Physician's Signature Physician's Name (printed)

_____
Date

THIS FORM MUST BE ON FILE WITH THE DISTRICT WORKERS' COMPENSATION OFFICE PRIOR TO SEEING THE ABOVE LISTED PHYSICIAN FOR A WORK-RELATED INJURY.

DISTRIBUTION: Original- District Workers' Compensation Office
Photocopies – Worksite, Physician, Employee