PACIFIC GROVE UNIFIED SCHOOL DISTRICT E-1
PERSONNEL OFFICE

PERSONAL PHYSICIAN DESIGNATION FORM

EMPLOYEE ___________________________________ POSITION _____________________________

PHYSICIAN'S NAME ____

PHYSICIAN'S PHONE NUMBER ____

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I hereby request that I be treated by my personal physician in the event of any "on-the-job" work injury.

EMPLOYEE SIGNATURE _____________________________________ DATE __________________

If you choose to designate your personal physician to treat you in the even of an "on-the-job" injury, You must also complete and return the Physician PRE-Designation Form to Human Resources

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WAIVER

I waive my right to be treated by my personal physician in the event of an "on-the-job" injury, or when my personal physician is not available.

EMPLOYEE SIGNATURE _____________________________________ DATE __________________

PACIFIC GROVE UNIFIED SCHOOL DISTRICT
555 Sinex Avenue Pacific Grove, California 93950

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Personal Physician Pre-Designation Form

Under Labor Code Section 4600 (d), if an employer offers non-occupational group health coverage and employee has the right, prior to being injured, to designate a physician to treat them for any industrial injury they may suffer. This physician must be the employee's primary care physician, not a chiropractor, have previously directed the medial treatment of the employee, and who retains the employee's medical records, including his or her medical history. For this election to be valid, the doctor must agree to treat your work related injury. We therefore require you to have you physician sign this form indicating an agreement to provide treatment under the workers' compensation laws of the State of California.

EMPLOYEE (complete this section)

I ______________________________, hereby select ______________________________
(Print Employee's Name) (Print Physician's Name)

to be my treating physician in the event I am injured at work.

I understand that this physician must be my regular, primary care physician, must have directed my medical treatment in the past, and must maintain my medical records including my medical history.

Employee Signature: ______________________________ Date: ______________

______________________ ______________________________
(Print Employee's Social Security Number) (Employee's Address)

(Note to Employee: It is the employee's responsibility to ask the physician to complete and sign the section below)

PHYSICIAN (complete this section)

I, Dr. ______________________________ agree to treat the above named patient, under the workers' compensation laws of the State of California, in the event they should suffer an industrial injury.

Physician Signature:______________________________Date:______________

Address: ______________________________

Telephone: ______________________ Fax: ______________________

Employee must return completed and signed form to Human Resource