County of Santa Clara

Office of the County Executive
Department of Risk Management
Worker's Compensation Division
2310 North First Street, Suite 205
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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:

- your employer offers group health coverage;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine or 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 multi- specialty medical group providing comprehensive medical services predominantly for non- occupational 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 lllness,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.
Unless an employee agrees, neither the employer nor the claims administrator shall contact your personal physician to confirm a predesignation. If your physician does not sign below, other documentation that they agreed to be predesignated prior to the injury will be required. Your signature below on this form will signify that you authorize your employer or claims administrator to contact the physician named below to confirm the predesignation.

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)
_____ (telephone number)
Employee Name (please print): _____
Employee's Address: _____
Employee's Signature:_____
Physician: I agree to this Predesignation:
Signature: _____Date:_____

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

The physician is not required to slgn 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 (0) (3). Title 8, California Code of Regulations, section 9783.

***** PLEASE RETURN THIS FORM TO YOUR HUMAN RESOURCES DEPT**