City of Riverside
Human Resources Department
Workers' Compensation Division

EMPLOYEE'S PRE-DESIGNATION OF PERSONAL MEDICAL PHYSICIAN FOR AN ON-THE-JOB INJURY (WORKERS' COMPENSATION)

If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. As defined in Labor Code 4600(d) allows for treatment by a pre-designated personal medical physician. The pre-designated physician **must be your regular, primary care physician** and must be licensed. This means that he or she has **previously directed your medical treatment and retains your medical records, including your medical history.** Further, the physician must agree to be pre-designated.

I understand that this doctor must have treated me in the past and must maintain my medical history records.

PLEASE PRINT:

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

Personal Physician: _____Type of Specialty: _____

Physician's Office Address: _____
(street, city, zip code)

Employee Name: _____Employee Number: _____

Address: _____
(street, city, zip code)

Phone Number: _____ Work Phone #: _____ Dept. _____

I declare under penalty of perjury that the above physician is my regular primary care physician, has previously directed my medical treatment, and retains my medical records.

_____ _____ _____
Employee/Volunteer's Name (Print) Employee/Volunteer's Signature Date

Please complete back of form before turning in form to Workers' Compensation

PHYSICIAN: Complete this section. I agree to treat the named individual should they have a work injury or illness. As required by law, I am licensed pursuant of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code. I am the regular primary care physician for the named individual and have previously treated this patient or directed their treatment, and retain medical treatment records, including his or her medical history. **I understand that medical services in the California workers' compensation system are to be preauthorized for non-emergency services, and diagnostic tests. All treatment plans must be pre-approved through the City of riverside's mandatory utilization review program (in accordance with the treatment guidelines of the American College of Occupational and Environmental Medicine.) Reporting requirements and fees are governed by the official Medical Fee Schedule adopted by the Division of Workers' Compensation California Labor code section 5307.1.**

Please Print:

Personal Physician: _____ Type of Practice: _____

Physician's Office Address**:** _____
(street, city, zip code)

Mailing Address if Different: _____

Phone Number: _____ Fax: _____ E-Mail: _____

Physician Tax I.D. Number: _____

I declare under penalty of perjury that the above information is correct:

Physician's Signature: _____ Date: _____