GARDEN GROVE UNIFIED SCHOOL DISTRICT
OFFICE OF PERSONNEL SERVICES
PERSONAL PHYSICIAN DESIGNATION FORM

PLEASE COMPLETE AND RETURN TO THE WORKERS' COMPENSATION DEPARTMENT WITHIN 30 DAYS

Section 4600 of the Labor Code provides that 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. For the purpose of this section, "personal physician" means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

Per Labor Code Section 4600 to qualify as your predesignated, personal physician, the physician must agree in writing, to treat you for a work related injury, must have previously directed your medical care and must retain your medical history and records. **Your predesignated physician must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.**

In order for you to be treated by your personal physician during the first 30 days of your occupational injury, as approved in Labor Code Section 4600, this form must be completed and on file in the Office of Personnel Services, prior to the injury.

I understand that this form, bearing the signature of both my physician and me, is a valid prior notification of the selection of my personal physician for treatment of occupational injury or illness. If, during the course and scope of my employment I experience an industrial injury or illness, I hereby designate my regular personal physician as the following:

PLEASE PRINT:

Physician's Name: _____

Address: _____

_____

Telephone: _____

☐ I do not wish to designate a personal physician.

_____ _____ _____
Employee Signature | Emp. # (or last 4 digits of S. S. #) | Date

_____ _____ _____
Employee Last Name (PLEASE PRINT) | First Name | Middle Name

PERSONAL PHYSICIAN: Our employee has indicated that he/she wishes to be treated by you in case of an occupational injury or illness. By your signature below you are stating your willingness to treat the aforementioned person for such injury or illness, to provide a DOCTOR'S FIRST REPORT OF INJURY within the required five day period, to abide by the present workers' compensation fee schedule, to furnish timely status reports to the Garden Grove Unified School District Workers' Compensation Department and to provide treatment that is subject to approval through the Utilization Review process.

_____ _____
Date | Physician's Signature