



CONTRA COSTA COUNTY SCHOOLS INSURANCE GROUP
 550 ELLINWOOD WAY - PLEASANT HILL CA 94523
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**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.A.C.) 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**