(Optional)

DESIGNATION OF PERSONAL PHYSICIAN FORM

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:

- the doctor is your 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 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 multispecialty 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 illness, 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.

EMPLOYEE (Complete this Section)

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

(select one)

Physician Name:_____ (MD☐ DO☐ or Medical Group☐)

Physician Street Address: _____

Physician City, State, ZIP:_____

Physician Telephone: _____

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

Employee Name:_____

Employee Signature:_____ Date: _____

(Note to Employee: It is the employee's responsibility to obtain the physician's completion of the following section)

PHYSICIAN (Complete this Section)

Physician Name (please print):_____

Address: _____

_____

Telephone:_____ Fax:_____

Physician Signature:_____ Date: _____

The physician is not required to sign 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 pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Employee must return completed and signed form to the:

UCSB Workers' Compensation
565 Mesa Road
Santa Barbara, CA 93106-5132
(or fax to: 1-805-893-8521)