



**The California Labor Code section 4600 allows an employee to pre-designate a “personal physician” at any time *prior* to a work-related injury or illness. If a pre-designated physician is not on file at the time of injury or illness, the employee must wait until 30 days after the injury or illness is reported to pre-designate.**

The law defines “personal physician” as meeting the following conditions:

1. The physician is the employee’s regular physician licensed as a medical doctor and a surgeon.
2. The physician is your primary care physician and has previously directed your medical treatment and who retains your medical records, including your medical history.
3. **\*The physician agrees to be pre-designated.**

\*Please note that many physicians do not treat work-related injuries or illnesses. Prior to completing this form, please check with your physician and ask them to indicate their willingness to treat you for a work-related injury or illness by signing this form.

If you are injured on the job and go to a physician other than the physician designated on this form, you may be responsible for the cost of treatment. You are required to promptly notify your supervisor of a work-related injury or illness. If you have any questions, please call the Workers’ Compensation Department at The Center for Human Resources at (619) 594-4664.

**Employee Section:**

Employee Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 In case of a job-related injury or illness occurring after the date of this notification I understand that I may be treated by my personal physician only with their prior approval. The personal physician I have designated has given his/her consent as shown by their signature below:

**Physician Certification:**

Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Tax ID: \_\_\_\_\_ License #: \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I am the individual named above, primary physician, and I am licensed as a physician and a surgeon. I agree to treat the above named individual should he or she suffer a work-related injury or illness and I have previously directed medical treatment for the employee listed above and retain his or her medical records (including medical history). I understand that medical services in the California Workers’ Compensation system are subject to pre-authorization for non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees governed by the Official Medical Fee Schedule established by the Division of Workers’ Compensation.