LOS ANGELES TRADE-TECHNICAL COLLEGE

WORKERS' COMPENSATION - Pre-Designation of Personal Physician

EMPLOYEE NAME	CLASSIFICATION

If you are injured on the job **you have the right to be treated by your personal physician if you notify us, in writing, prior to the injury. To qualify as your pre-designated, 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 (Labor Code 4600). Your pre-designated physician must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

This is an optional form that can be used to notify us of your personal physician. You may choose to use another form, as long as you notify us, **in writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be pre-designated. Otherwise, you will be treated by one of our designated worker's compensation medical providers.

EMPLOYEE ACKNOWLEDGEMENT (Choose one)

❑ **I acknowledge receipt of this form and elect not** to pre-designate my personal physician at this time. I understand that in the event of a work related injury or illness, I will receive medical treatment from my employer's medical provider. I understand that, at any time in the future, I can change my mind and provide written pre-designation of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

OR

❑ **If I am injured on the job, I wish to be treated by my personal physician.** This physician is my personal physician who has previously directed my medical care and retains my medical history and records.

Name of Physician _____ Phone Number _____

Physician Address _____

Employee Signature: _____ Date: _____

The remainder of this form is to be completed by your physician and returned to Human Resources.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other **written** 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).

❑ **I agree to treat the above named employee in the event of an industrial accident or injury AND I meet the criteria outlined above**. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

Physician Signature: _____ Date: _____

Printed Name: _____

Please return completed form to:

Los Angeles Trade Technical College
Cooperative Work Experience Education
400 West Washington Blvd.
Los Angeles, CA 90015
DamMC@lattc.edu