

Pre-Designation of Physician for Occupational Illness or Injury

Employer Information

Employer Name: _____
Address: _____
Telephone: _____

Employee Information

Employee Name: _____
Address: _____
Telephone Number: _____ Date of Hire: _____

I, _____ pre-designate Dr. _____ located at _____ who is a (MD, DO, DC, LAC circle one) to treat me for occupational illness or injury. I understand that the physician I pre-designate must have treated me in the past, must maintain my medical records and must agree in writing to be pre-designated to treat me in the event of an occupational illness or injury. I also understand that if I pre-designate a personal chiropractor (DC) or acupuncturist (LAC) PEIC will arrange treatment with another doctor, then I may switch to the chiropractor or acupuncturist upon request during the first 30 days after reporting the injury or illness to my employer.

Employee: I understand I can be treated immediately by my personal medical doctor MD or a doctor of osteopathy (DO) if my employer offers group health coverage; the doctor has treated me in the past and maintains my medical records; prior to the injury the doctor agreed to treat me for work injuries or illnesses and I gave my employer the doctor's name and address in writing.

Employee Signature: _____
Date Completed: _____

Physician: In accordance with California Labor Code 4600, I agree to treat the employee's work injury or illness and I understand that medical services are subject to preauthorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees governed by the Official Medical Fee Schedules. I confirm to have previously directed the employee's treatment.

Physician's Signature/Approval: _____
Date Signed: _____

This form should be maintained with employee records and provided to the insurance carrier in the event of occupational injury or illness.