DOWNEY UNIFIED SCHOOL DISTRICT
Certificated Human Resources

TO: All Certificated Employees
FROM: Alyda R. Mir, Assistant Superintendent, Certificated Human Resources

SUBJECT: **Pre-designation of Personal Physician to Treat Work-incurred Injuries**

In accordance with California Labor Code section 4600, you have the right to pre-designate a "personal physician" for the purpose of treating work-incurred injuries. By so doing, you may be treated by your personal physician for injuries which occur on the job, rather than going to the District's medical provider.

To exercise your right to pre-designate you must notify the District in writing of the name and address of your personal physician. A definition of "personal physician" follows:

- ☐ The employee's regular physician and/or surgeon,
- ☐ Who, prior to the injury, has directed medical treatment of the employee, and
- ☐ Retains the medical records and medical history of the employee.

Due to a recent change in law, it is necessary for your personal physician to agree to be your pre-designated physician. Your physician must adhere to Title 8, California Code of Regulations 9785, the "Reporting Duties of the Primary Treating Physician" and Labor Code 4610.

Your physician must sign the certification on the back of this form. Once that has been done and you have completed the lower portion of this page, turn the pre-designation form in to the Certificated Personnel Services at the District Administration Building. All employees must complete this form on both sides before they can see their own physician in case of a work-incurred injury. This form will NOT be honored without the certification by your physician on the reverse side.

The District's medical provider for on-the-job injuries is:
Health First Medical Group
11817 East Telegraph Road, Santa Fe Springs, CA 562-949-9328

This is to notify the Downey Unified School District that in case I am injured on the job, I wish to be treated by my own personal physician as noted below. My physician has completed the certification on the reverse side of this form.

(please print)

Name of Physician:
_____

Address: _____
(Number / Street) (City) (Zip)

Specialty: _____ Phone Number: _____

_____ _____
Employee Name Employee Signature

Date_____

_____ _____
Job Title Work Location

To be completed by employee:

Date: _____

Physician: _____

Re. Employee: _____
(insert your name)

CERTIFICATION BY PHYSICIAN

This is to certify that _____ is a patient of mine.
(insert employee's name)

I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I am willing to take responsibility for following rules required of a Treating Physician per California Code of Regulations, Title 8, Section 9785, when treating this employee for work-related injuries or illnesses.

I acknowledge all requests for medical care will be governed by Labor Code 4610 outlining mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM).

Physician's Signature: _____

Physician's Name (printed): _____

Date: _____

OR,

I decline the request of _____ to be his/her
(insert employee's name)

Treating Physician for work-related injuries or illnesses.

Physician's Signature: _____

Physician's Name (printed): _____

Date: _____