SAN MATEO COUNTY COMMUNITY COLLEGE DISTRICT

Office of Human Resources
3401 CSM Drive – San Mateo, CA 94402
Automated Service Line: (650) 574-6555
Fax: (650) 574-6574

workers' Compensation: Pre-Designation of Personal Physician

You have the right to be treated immediately by your personal physician if you notify SMCCCD, in writing, prior to the injury. Per Labor Code 4600 to qualify as your predesignated, personal physician(M.D./D.O), the physician must agree to treat you for a work related injury, must have previously directed your medical care, and must retain your medical history and records.

Please use this form to notify SMCCCD to designate your personal physician. Otherwise, you will be treated by one of our designated workers' compensation panel facilities (listing in our new hire injury/illness reporting packet).

EMPLOYEE NAME: _____

☐ **I acknowledge receipt of this form and elect not** to predesignate my personal physician at this time. I understand that I will receive medical treatment from SMCCCD designated workers' compensation panel facilities. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

☐ **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's Address: _____
Name of Personal health insurance plan coverage: (non-occupational injuries or illnesses)

_____

Employee Signature: _____ Date: _____

A *Personal Physician* must be willing to be a designated physician and treat you for a workers' compensation injury/illness.
The remainder of this form is to be completed by your physician and returned to SMCCCD.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify **you must agree to be designated as the employee's personal physician and treat this employee for a work related injury**. You must have previously directed the employees medical care and retain their medical history and records. Our primary goal is to provide our employees with prompt, effective, quality medical treatment in the event of an industrial injury. We request your partnership by completing this acknowledgement form.

Personal Physician Name: _____

☐ **I agree to treat the above named employee in the event of an industrial accident or injury**. I have previously directed the employee's medical treatment and retain medical records and medical history. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

☐ **I do not agree to treat the above employee in the event of an industrial accident or injury.**

☐ **I do not qualify as the employees' personal physician** per Labor Code 4600. I have not previously directed the employee's medical treatment and do not retain medical records and medical history.

Physician Signature: _____ Date: _____

Return Completed Form to: Fax (650) 574-6574, Human Resources, SMCCCD, 3401 CSM Drive, San Mateo, CA 94402

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