California State University
Dominguez Hills

Human Resources Management
Carson, CA •(310) 243-3771 • FAX: (310) 217-6947

NOTICE OF DESIGNATION OF PERSONAL PHYSICIAN

(Medical Treatment for a Work Related Injury or Illness)

In the event you sustain injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), a doctor of osteopathic medicine (D.O.) or a medical group, if:

- Your employer offers group health coverage;
- **The doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;**
- Prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- Prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

EMPLOYEE DESIGNATION OF A PERSONAL PHYSICIAN

If I sustain an injury or illness while acting within the course and scope of my employment at Cal State Dominguez Hills, I hereby elect to be treated by my personal physician (M.D., D.O., or medical group), named below, from the date of injury.

My personal physician is:

Name _____
(Please Type or Print Full Name of Physician)

Employee's Name _____ Department _____
(Please Print Full Name)

Employee Signature _____ Date_____

PERSONAL PHYSICIAN ACCEPTANCE OF EMPLOYEE DESIGNATION

I agree to be the designated personal physician for _____. I am the regular physician or primary care physician (M.D. or D.O.) and meet the physician designation criteria as outlined above in bold print. I understand that I am expected to comply with Title 8, California Code of Regulations, section 9783 and, Reporting Duties of the Primary Treating Physician, section 9785.

Physician's Name _____
(Please type or print)

Address _____

_____

Phone Number (_____) _____

Physician's Signature _____ Date_____

Return this form to: California State University, Dominguez Hills
Human Resources Management
1000 E. Victoria Street, Welch Hall A-340
Carson, California 90747

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