

**Pre-Designation of Personal Physician**

In the event you sustain an 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.

**NOTICE OF PRE-DESIGNATION OF PERSONAL PHYSICIAN**

If you wish to pre-designate your personal physician, this form must be completed and signed by you and your personal physician.

EMPLOYEE INFORMATION	
Employee Name:	
Department:	Extension:

EMPLOYEE PERSONAL PHYSICIAN PRE-DESIGNATION	
If I sustain an injury or illness while acting within the course and scope of my employment at California State University, Dominguez Hills, I hereby elect to be treated by my personal physician (M.D. or D.O.), named below, from the date of injury	
My Personal Physician is (full name):	
Employee Signature:	Date:

**PERSONAL PHYSICIAN ACCEPTANCE OF EMPLOYEE PRE-DESIGNATION**

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

Physician Name:	Office Phone:
Physician Address:	
Physician 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