San Juan Unified School District
Pre-Designated Physician Form

<u>Return completed form to the Workers' Compensation Dept.</u>

This Section to be completed by employee:

Date:______________________

Employee Name: ____SS#__________________________

Work Site: ____ Position: _____________________________

In the event of any on-the-job, work-related injury, I request that I be treated by my personal physician as indicated below:

Personal Physician: ____

Physician's Address: ____

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Physician's Phone Number: ____

Important Requirements for Personal Physicians:

- The physician is the employee's regular physician (MD). (DO), licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
- The physician is the employee's primary care physician under their medical plan and has previously directed the medical treatment of the employee, and retains the employee's medical records, including his or her medical history.
- The physician agrees to be predesignated and has signed approval below.

Kaiser members – Please note that we <u>do not</u> require a physician's signature if you are designating a Kaiser physician.

Employee Signature:___________________________________ **Date**:______________________

This section to be completed by Personal Physician:

I agree to be the Pre-Designated Physician for the above-referenced individual for the treatment of work-related injuries. I understand that payment will be made at reasonable maximum amounts in the official medical fee schedule, pursuant to Section 5307.1 of the Labor Code in effect on the date of service. Payments shall be made by the employer within 45 working days after receipt of each separate itemization of medical services provided, together with any required reports and any written authorization for services that may have been received by the physician.

Physician's Signature:_________________________________ **Date**:______________________