

California State University Fresno

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Pursuant of Title 8, California Code of Regulation, section 9780.1(a)(3): The employee's personal physician agrees to be predesignated prior to the injury. The personal physician may sign the optional predesignation form (**DWC Form 9783**) as documentation of such agreement. The physician may authorize a designated employee of the physician to sign the optional predesignation form on his/her behalf. If the personal physician or the designated employee of the physician does not sign a predesignation form, there must be other documentation that the physician agrees to be predesignated prior to the injury in order to satisfy this requirement.

Labor Code Section 4600 and section 9780.1 permits the employee, the right to be treated by a "personal physician" if the physician is designated prior to the injury or illness. 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.) or doctor of osteopathic medicine (D.O.) **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, business address, and signature.
- 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

Employee: Complete this section.

To: **California State University, Fresno**. If I have a work related injury or illness, I choose to be treated by:

(name of doctor) (M.D., D.O.)

Employee Name **(please print)** _____ **(telephone number)** _____

Employee Address: _____

Employee Signature: _____ Date: _____

Physician: Complete this section.

Physician's Address: (street address, city, state, zip) (telephone number)

Physician: I agree to this Predesignation:

Signature: _____ Date: _____

Physician or Designated Employee of the Physician)