DWC FORM 9783 (March 1, 2007) PREDESIGNATION 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.) 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;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- 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

You (the employee) sign this section.

Employer _____

Employee Name* _____

_____

Employee ID#* _____

Date of Hire _____

Date of Birth _____

Address _____

City _____

St, Zip _____

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

Signature X _____

Date _____

PHYSICIAN

We cannot process this form without the fields marked bold with an asterisk.

Please PRINT clearly. _____

Physician First Name* _____

Physician Last Name* _____

Street Address*
of the physician's practice _____

City* _____

St, Zip* _____

Telephone Number
of the physician's practice (_ _ _) _ _ _ - _ _ _ _

Group Name: _____

CA License _____

I agree to this Predesignation:

Physician Signature X _____

Date of Acceptance _____

The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Employee: Complete this form and give to your supervisor. Supervisor: Place this form in employee's personnel file.