SJSU SAN JOSÉ STATE UNIVERSITY

PREDESIGNATION OF PERSONAL PHYSICIAN FORM

HUMAN RESOURCES | 408-924-2250

Instructions: *Any employee who wishes to predesignate a personal physician must complete section A of the form and have your physician complete section B.* ***Return the entire form to the attention of the Workers' Compensation Manager in Human Resources.*** *A copy of the completed form will be returned to the employee for future reference.*

Information:
The California Labor Code states that an employer may choose the provider of medical care for the first 30 days following the date an industrial injury/illness is reported, unless the employee has submitted, in writing, the name of his/her predesignated personal physician. A personal physician must meet all of the following conditions:

1. 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;
2. prior to the injury your doctor agrees to treat you for work injuries or illnesses;

Employees injured at work should report to the SJSU Student Wellness Center for initial treatment. Anyone needing further care and has not pre-designated a treating physician will be referred to a University designated provider.

A. EMPLOYEE SECTION	
I certify that the individual named below is my personal physician and designate him/her as my medical provider in the case of work-related injuries or illness.	
(Name of doctor)(M.D., D.O., or medical group):	
Employee Name (print):	SJSU Department:
Signature of Employee:	Date:

B. PHYSICIAN SECTION	
I am the employee's regular or primary care physician and have previously directed his/her medical treatment and retain their medical records, including medical history. I agree to be the predesignated personal physician for:	
Employee's Name:	
Physician's Name (print):	
Physician's Address:	
Physician's Phone Number:	
Physician's Signature:	Date:
This form may be returned to the employee requesting your acceptance of pre-designation or mailed directly to the office listed at the top of this form.	

FOR WORKERS' COMPENSATION OFFICE USE ONLY		
Date form received:	Original to WC Office	Copy to Employee on: