



**PRE-DESIGNATION OF PERSONAL PHYSICIAN**

In the event you sustain in 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:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- 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.

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

**Employee: Complete this section.** If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_  
(name of doctor) (M.D., D.O., or medical group)

\_\_\_\_\_  
(street address, city, state, ZIP)

\_\_\_\_\_  
(telephone number)

Employee Name (please print)

\_\_\_\_\_  
Employee home address, city, state, ZIP

\_\_\_\_\_  
Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

Employee’s Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Physician: I agree to this Pre-designation:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician’s agreement to be pre-designated will be required pursuant to the Title 8, California Code of Regulations, section 9780.1(a)(3). Title 8, California Code of Regulations, section 9783.

Return this form to: California State University, Fullerton  
Risk Management, CP-700  
800 N. State College Blvd., Fullerton, California 92831