VENTURA COUNTY COMMUNITY COLLEGE DISTRICT

PERSONAL PHYSICIAN PREDESIGNATION

TO: Workers' Compensation, District Administration Center

FROM:_____ _____
Employee Name (Please Print) Date

_____ _____
Campus or Work Site Employee Position & Employee ID #

I hereby request that my personal physician identified below treat me in the event of an "on-the-job" work related injury. I understand that, because the District offers group health insurance, I have the right to be treated by my personal physician, only if I made this designation PRIOR to my work related injury.

The employee must have an established physician-patient relationship with the physician who must also retain the employee's medical history and past medical records. The selected physician must be able to meet the statutory requirements to qualify as a personal physician under California Labor Code §4600 and as defined by the Business & Professional Code, Chapter 5, commencing with Section 2000. Copies of these requirements are available from the Workers'Compensation Department on request or from the Internet (www.leginfo.ca.gov).

Employee's Signature _____

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Physician: Please Complete This Section
This is to certify that the named individual above is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I am willing to take responsibility for following the rules required of a Treating Physician per California Code of Regulations, Title 8, Industrial Relations, Section 9785, when treating this employee for work related injuries or illnesses. I acknowledge all requests for medical care will be governed by California Labor Code 4600, et. seq., outlining mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM). I am familiar with the "AMA Guides to the Evaluation of Permanent Impairment", 5th Edition.

_____
Physician's Name (Please Print)

_____
Physician's Full Address

_____ _____
Physician's Phone Number Physician's Fax Number

_____
Physician's Office Manager/Billing Contact Name(s)

_____ _____
Physician's Signature Physician's Tax I.D. Number

Reminder: For this predesignation of your personal physician to be valid, this completed form must be submitted to the District Workers' Compensation Office, PRIOR to any work related injury. *Please be assured that if you are injured on the job and have not submitted this form, the Ventura County Community College District will provide you with excellent medical treatment for your work related injury from one of our approved medical clinics.*

(Rev. 05/09)