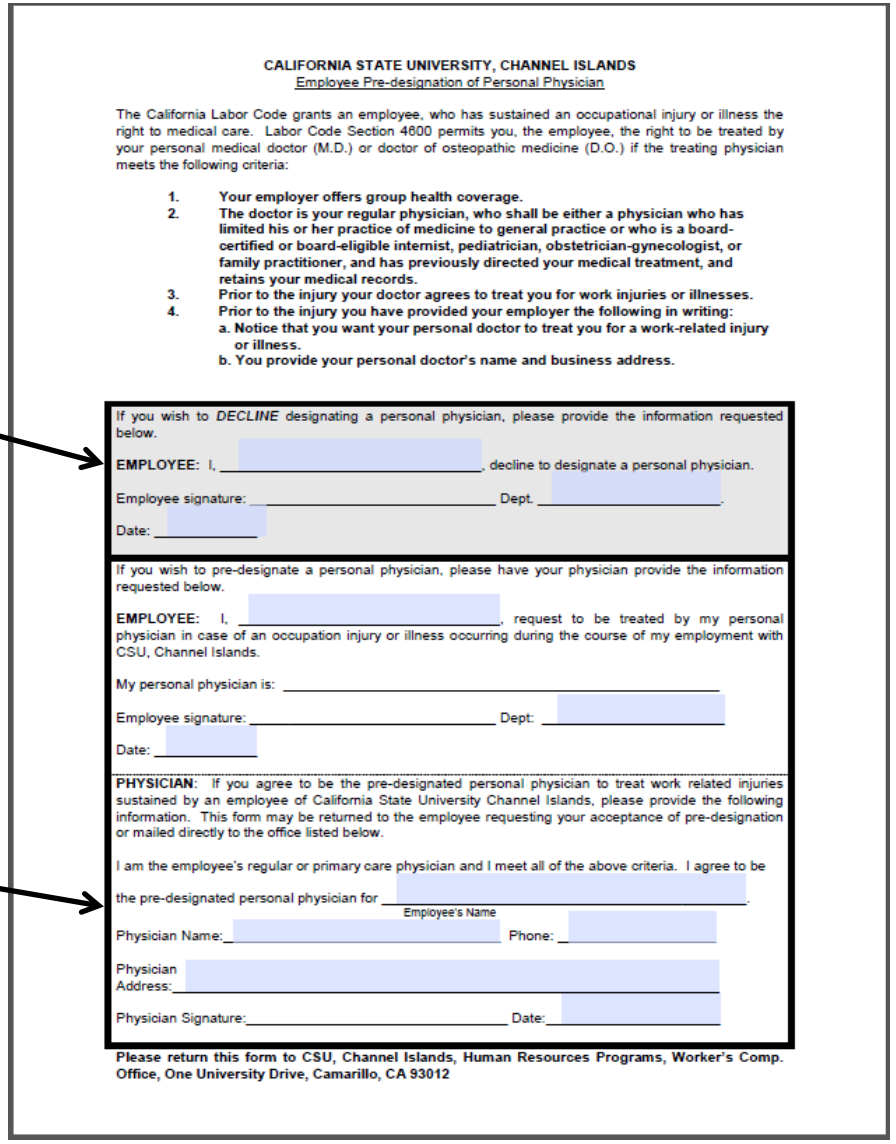
This form is for work related injuries ONLY

Complete this section to be sent to US HealthWorks, at no cost to you, for a work related injury

If your preference is to go directly to your own doctor for a work related injury, please print form and have your doctor complete & sign this portion, indicating they will accept Workers Compensation. Once that is complete then, you complete middle section of form and return form to HR.



CALIFORNIA STATE UNIVERSITY, CHANNEL ISLANDS

Employee Pre-designation of Personal Physician

The California Labor Code grants an employee, who has sustained an occupational injury or illness the right to medical care. Labor Code Section 4600 permits you, the employee, the right to be treated by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) if the treating physician meets the following criteria:

1. **Your employer offers group health coverage.**
2. **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.**
3. **Prior to the injury your doctor agrees to treat you for work injuries or illnesses.**
4. **Prior to the injury you have provided your employer the following in writing:**
   a. **Notice that you want your personal doctor to treat you for a work-related injury or illness.**
   b. **You provide your personal doctor's name and business address.**

If you wish to *DECLINE* designating a personal physician, please provide the information requested below.

EMPLOYEE: I, _____, decline to designate a personal physician.

Employee signature: _____ Dept. _____.

Date: _____

If you wish to pre-designate a personal physician, please have your physician provide the information requested below.

EMPLOYEE: I, _____, request to be treated by my personal physician in case of an occupation injury or illness occurring during the course of my employment with CSU, Channel Islands.

My personal physician is: _____

Employee signature: _____ Dept: _____

Date: _____

PHYSICIAN: If you agree to be the pre-designated personal physician to treat work related injuries sustained by an employee of California State University Channel Islands, please provide the following information. This form may be returned to the employee requesting your acceptance of pre-designation or mailed directly to the office listed below.

I am the employee's regular or primary care physician and I meet all of the above criteria. I agree to be the pre-designated personal physician for _____ (Employee's Name).

Physician Name: _____ Phone: _____

Physician Address: _____

Physician Signature: _____ Date: _____

Please return this form to CSU, Channel Islands, Human Resources Programs, Worker's Comp. Office, One University Drive, Camarillo, CA 93012