APPENDIX "I"
NOTICE OF ELECTION TO BE TREATED
BY PERSONAL PHYSICIAN OR MEDICAL FACILITY

TO: Human Resources, Glendale Community College

FROM: _____
(name of employee)

You are hereby notified, pursuant to Section 4600 of the Labor Code of California, and Article VII, Section 5 of the Collective Bargaining Agreement, that if I sustain an industrial injury, I elect to be treated for such injury by my personal physician or medical facility. The name and address of my personal physician or medical facility is:

_____
(*name of physician or medical facility)*

_____
(address – street or P.O.#)

_____
(city) *(zip)*

_____
(telephone number – including area code)

This notice and election shall remain in full force and effect until revoked in writing by the undersigned employee.

Dated: _____

_____ _____
Employee name (print) *Employee signature*

Receipt of this notice acknowledged this _____ day of _____, 20 _____

A Personal Physician *must be willing to be pre-designated and treat you for a worker's compensation injury.* **The remainder of this form is to be completed by your physician and returned to your Employer.**

P E R S O N A L P H Y S I C I A N A C K N O W L E D G E M E N T

Per Labor Code 4600 **to qualify as a pre-designated physician you must agree, in writing, to treat _____ for work related injuries**

Employee name (print)

and must have previously directed his/her medical care and must retain his/her medical history and records . In addition, you must be a general practitioner, family practitioner, board certified or board eligible internist, pediatrician or obstetrician-gynecologist.

Written documentation of the physician's agreement to be pre-designated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN NAME:

_____

- ❑ ***I agree to treat*** **the above named employee in the event of an industrial accident or injury**. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.
- ❑ ***I do not agree*** **to treat the above employee in the event of an industrial accident or injury.**
- ❑ ***I do not qualify*** **as the employees' personal physician**. I am not an M.D. or D.O. or do not meet the criteria outlined above.

_____

Physician Signature

_____

Date

You are not considered eligible to use the pre-designated physician in the event of injury, unless both pages of this form have been completed, including signatures, and returned to the Human Resources Department. Forms can be returned to:

Glendale Community College
Attention: Workers' Compensation
1500 N. Verdugo Road
Glendale, CA 91208

Or

Faxed to (818) 551-5169 attention: Workers' Compensation