EMPLOYEE PRE-DESIGNATION OF TREATING PHYSICIAN

Employee Name____________________________ Social Security Number__________________

Address __________________________________ Date of Birth __________________________

City/State/Zip ______________________________ Date of Hire ____________________________

I. I hereby designate the physician listed below as my treater, in the event of an on-the-job injury occurring on or after the date of this notice.

Doctor's Name: ____

Address: ____

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Phone: ____

II. I certify the physician is my primary care physician and has previously directed medical treatment to me and retains my medical records, including my medical history.

III. My physician agrees to be predesignated.

IV. My employer provides non-occupational group health care coverage.

Employee Signature:__________________________________ Date:______________________

I agree to be predesignated and I am a physician, licensed pursuant to Chapter 5 of Division 2 of the Business and Professionals Code.

Physician's Signature:________________________________ Date:______________________