CONEJO VALLEY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
1400 E. Janss Road, Thousand Oaks, California 91362
Telephone (805) 497-9511 · FAX (805) 494-3741

NOTICE OF PRE-DESIGNATION OF PERSONAL PHYSICIAN

Employee Last Name	First Name	Middle Initial	Suffix

Social Security # (last 4)	Date of Birth (MM/DD/YYYY)	Position
XXX - XX -		

EMPLOYEE ACKNOWLEDGEMENT OF NON-ELECTION OF PREDESIGNATED PERSONAL PHYSICIAN

I acknowledge receipt of this form and elect not to pre-designate my personal physician at this time. I understand that, at anytime in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file with the District prior to an industrial injury.

Employee Signature _____ Date _____

I: EMPLOYEE - COMPLETE THIS SECTION TO REQUEST PREDESIGNATON OF PERSONAL PHYSICIAN:

INSTRUCTIONS: In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) if:

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. 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 non-occupational illnesses and injuries;
4. Prior to the injury your doctor agrees to treat you for work injuries or illnesses;
5. Prior to the injury you provided CVUSD (employer) the following notice 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.

**** COMPLETION OF THE INFORMATION BELOW WILL SATISFY THE NOTICE REQUIREMENT ****

If I have a work-related injury or illness, I choose to be treated by:

_____, at
Name of Physician (M.D., D.O.) or Medical Group (please print)

_____
Physician Street Address City State Zip

The above physician is my personal physician who has previously directed my medical care and retains my medical history and records.

I understand that I am responsible for signing the document below and seeking agreement and signature from my personal physician. I understand that ***the completed document MUST be returned to the CVUSD Human Resources Department*** prior to a work-related injury or illness, otherwise my request for pre-designation is not valid. I further understand that the physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other 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).

Employee Signature _____ Date _____

II: PHYSICIAN - COMPLETE SECTION BELOW TO ACCEPT THE PRE-DESIGNATION:

I agree to treat the above named individual should they have a work injury or illness. I understand that medical services are subject to preauthorization of non-emergency services and diagnostic tests, utilization review, reporting requirements, and fees are governed by the Official Medical Fee Schedule promulgated by the Division of Workers' Compensation.

Physician Name (please print) _____ Phone Number _____

Physician Signature _____ Date: _____