



WORKERS' COMPENSATION PERSONAL PHYSICIAN NOTIFICATION FORM

TO: Personnel Department

FROM: _____

NAME

ADDRESS

CITY

TELEPHONE

TO WHOM IT MAY CONCERN:

1. I, _____, hereby designate, pursuant to Labor Code 4600(d) et seq., my personal physician, _____, for medical treatment of any injuries or illnesses arising out of, and in the course of, my employment.

_____ Date

_____ Employee

2. I, _____, (personal physician), hereby state that:

- a. I am the personal physician of _____
- b. I am the primary care physician of _____ and have previously directed medical treatment of _____ and I retain his/her medical records, including his/her medical history.
- c. I agree to be predesignated for purposes of Workers' Compensation.

_____ Date

_____ Doctor

THIS NOTIFICATION IS MADE PURSUANT TO SECTIONS 4600 AND 4601 OF THE CALIFORNIA LABOR CODE.

SIGNED: _____

DATED: _____

IMPORTANT: KEEP A COPY OF THIS NOTIFICATION FOR YOUR RECORDS.

WHITE: EMPLOYER COPY

CANARY: UNION COPY

PINK: EMPLOYEE COPY