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 osteopathy (D.O.) if: -

- **your employer offers group health coverage;**
- **the doctor has treated you in the past and has your medical records;**
- **<u>prior to the injury</u> your doctor agreed to treat you for work injuries or illnesses;**
- **<u>prior to the injury</u> you provided your employer the following 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.

This form may be used to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathy treat you for a work-related injury or illness <u>and the above requirements are met.</u>

****

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

<u>EMPLOYEE: COMPLETE THIS SECTION</u>

To: ______________________________________

Employer Name

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

____
Name of Physician

____
Street Address of Physician **City, State** **ZIP**

Employee Name: ____
Last **First** **M.I.**

Employee Signature:____ **Date:** ______________________

<u>PHYSICIAN: COMPLETE THIS SECTION</u>

I AGREE TO THIS PREDESIGNATION

Physician Signature: ____**Date:** ______________________
Physician or Designated Employee of Physician

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 Section 9780.1(a)(3).

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<u>EMPLOYER: COMPLETE THIS SECTION</u>

PREDESIGNATION RECEIVED AND ACCEPTED BY:

____ **Date:** ______________________
Name **Title**

COPY TO: Employer
Local 70