

**STATEMENT of PERSONAL PHYSICIAN DESIGNATION  
and PRE-DESIGNATED PHYSICIAN FORM**

TO: WEST CONTRA COSTA UNIFIED SCHOOL DISTRICT

FROM:

\_\_\_\_\_  
Last Name (type or print legibly)    First Name    Social Security Number  
\_\_\_\_\_  
Work Site (type or print legibly)    Position/Classification

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I hereby request that I be treated by my personal physician in the event of any work related injury.

\_\_\_\_\_  
Physician's Name (type or print legibly)    (    )  
Phone Number

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Employee Signature    Date

=====

**TO BE COMPLETED BY PHYSICIAN:**

I/we have directed the medical treatment for \_\_\_\_\_  
Employee Name (type or print legibly)

in the past, and retain the medical records and medical history for this individual.

Furthermore, I/we agree to provide all necessary and reasonable medical treatment to this individual, in the event of a work related injury or illness sustained by him/her while being employed by the West Contra Costa Unified School District.

I we agree to abide by the Administrative Director's Rules and Regulations, Section 9785 and 9791, regarding the duties of the employee designated physicians and the official medical fee schedule.

\_\_\_\_\_  
Physician's Name (type or print legibly)

\_\_\_\_\_  
Physician's Signature

**THIS FORM MUST BE ON FILE WITH THE WORKERS' COMPENSATION OFFICE  
PRIOR TO SEEING THE ABOVE LISTED PHYSICIAN  
FOR A WORK RELATED INJURY**

Distribution:    White - Workers' Compensation Office    Yellow - Work Site    Pink - Employee