University Enterprises, Inc.
SACRAMENTO STATE
6000 J Street
Hornet Bookstore Bldg., Suite 3900
Sacramento, CA 95819-6063

Human Resources
(916) 278-7003
FAX (916) 278-4787
www.enterprises.csus.edu

PREDESIGNATION OF PERSONAL PHYSICIAN

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.), doctor of osteopathic medicine (D.O.) or medical group if:

- On the date of your work injury you have health coverage for injuries and illnesses that are not work related;
- 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;
- 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;
- Prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- Prior to the injury you provided University Enterprises, Inc. 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.

You may use this form to notify University Enterprises, Inc. if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

EMPLOYEE: COMPLETE THIS SECTION.

To: **University Enterprises, Inc.** If I have a work-related injury or illness, I choose to be treated by:

_____
Physician Name, (M.D., D.O., or medical group)

_____
Physician Address City State Zip

(_____) _____- _____
Physician Telephone

Employee Name (please print): _____

_____
Employee Address City State Zip

_____
Name of Insurance Company, Plan, or Fund providing health coverage for non-occupational injuries or illnesses

Employee's Signature_____Date:_____

PHYSICIAN: I AGREE TO THIS PREDESIGNATION:

Signature: _____Date:_____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9870.1(a)(3).