

**EMPLOYEE'S DESIGNATION OF
PERSONAL PHYSICIAN**

EMPLOYER NAME: _____

ADDRESS: _____

ATTENTION PERSONNEL DEPARTMENT:

This letter serves as notification that if, during the course of employment, I experience an industrial injury I hereby request to be treated by my personal physician:

Physician's Name

Address

Telephone Number

This physician has previously directed my treatment and retains my records including history. I hereby designate this physician as my "PERSONAL PHYSICIAN" under California Labor Code Section 4600.

I have read the above statements and to the best of my knowledge and belief the facts stated are accurate and in full compliance with legal requirements.

Employee's Signature

Date: _____

Authorized Personnel Office Signature

Date Received: _____