PERSONAL PHYSICIAN OR PERSONAL CHIROPRACTOR
Predestination Form

(To be completed by employee)

I, the undersigned employee, in case of an industrial injury or illness, elect to receive medical treatment from my personal physician/personal chiropractor.

I understand that Labor Code Section 4600 defines my "personal physician" as my "regular physician and surgeon" who has previously directed my medical treatment and who retains my medical records, including my medical history.

I understand that Labor Code Section 4601 defines my "personal chiropractor" as my "regular chiropractor" who has previously directed my treatment and who retains my chiropractor treatment records, including my chiropractor history.

Check one:

( ) Personal Physician _____
Name

Or _____
Address

( ) Personal Chiropractor _____ _____ _____
City State Zip

_____
Telephone

Employee Name: _____

Department: _____

_____ _____
Employee Signature Date

To Be Completed By Your Doctor

I hereby accept pre-designation as the primary healthcare provider for occupational injuries or illnesses of the above named patient. I have previously treated this patient and maintain his/her medical records.

_____ _____
Signature Date

FORMA DE MEDICO O CHIROPRACTICO
Personal Predesignado

(Completado por el empleado)

Yo, el empleado, en caso de una lesión industrial o enfermedad, eligo recibir tratamiento medico de mi doctor personal/chiropractico personal.

Yo entiendo que Codigo Laboral Seccion 4600 define mi "doctor personal" como mi "doctor regular y cirujano" quien ha previamente dirigido mi tratamiento medico y quien retien mi record medico, incluyendo mi historia medica.

Yo entiendo que Codigo Laboral Seccion 4601 defines mi "chiropractico personal" como mi "chiropractico regular" quien ha previamente dirigido mi tratamiento y quien retiene mi record de tratamiento chiropractico, incluyendo mi historia chiropractico.

Eliga uno:

( ) Doctor Personal _____
Nombre

Or _____
Dirección

( ) Chiropractico Personal _____ _____ _____
Ciudad Estado Codigo Postal

_____
Teléfono

Nombre del Empleado : _____

Departamento: _____

_____ _____
Firma del Empleado Fecha

Completado Por El Medico

Yo aquí acepto la pre-designación como el proveedor de salud primario por lesions ocupacionales o enfermedades del paciento arriba nombrado. Yo he previamente tratado a este paciente y mantengo sus records médicos.

_____ _____
Firma Fecha