

# GLENDORA UNIFIED SCHOOL DISTRICT

500 North Loraine Avenue, Glendora, CA. 91741  
(626) 963-1611 • Fax (626) 335-2196 • Web Site [www.glendora.k12.ca.us](http://www.glendora.k12.ca.us)

Date: March 1, 2017  
To: All Employees  
From: Marc Chaldu  
Re: **Workers' Compensation Pre-Designation of Personal Physician**

On March 15, 2006, the Rules and Regulations governing the process by which employees pre-designate a personal physician for the treatment of a potential future work-related injury were substantially modified.

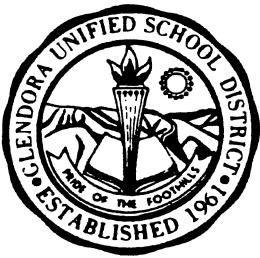
In order for an existing pre-designation notice to be considered valid, the following criteria must be met:

- 1) Your notice must be in writing and must include your personal physician's name and business address. Glendora Unified School District has an optional form (DWC Form 9783) that can be used for this purpose. This form is available at all school or district administrative offices or by contacting Janna Wells x361.
- 2) The personal physician whom you have designated must be a medical doctor or doctor of osteopathic medicine who is a general practitioner or a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner. Additionally, he or she must be your regular physician who has previously directed your medical care and who retains your medical records, including your medical history.
- 3) Your pre-designated personal physician or his or her designee must agree to be your pre-designated personal physician prior to a possible work-related injury or illness. The optional form that is referenced in section (1) above contains a section where this agreement can be documented. If your personal physician is unable to sign the optional DWC Form 9783, there must be other documentation that your personal physician agrees to be pre-designated prior to a possible work-related injury or illness.

We do not consider pre-designation notices valid if they do not meet the criteria outlined above, and should you sustain a work-related injury or illness, you will be eligible to secure your treatment through the WellComp Medical Provider Network.

Please do not hesitate to contact me or Janna Wells x361 if you need additional information, assistance, or confirmation of your form on file.

(Please see form on reverse side.)



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## 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:

- your employer offers group health coverage;
- 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 nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury 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.

You may use this form to notify your employer 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: **Glendora Unified School District:** If I have a work-related injury or illness, I choose to be treated by:

\_\_\_\_\_  
(Name of doctor)(M.D., D.O., or medical group)

\_\_\_\_\_  
(Street address, city, state, ZIP)

\_\_\_\_\_  
(Telephone number)

Employee Name (please print): \_\_\_\_\_

Employee's Address: \_\_\_\_\_

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 9780.1(a)(3). Title 8, California Code of Regulations, section 9783. (Optional DWC Form 9783 March 1, 2007)