OPTIONAL PRE-DESIGNATION OF PHYSICIAN FOR WORKERS' COMPENSATION:

Aspire Public Schools strives to provide a safe working environment for all staff members. In the event of a work injury, Aspire provides Workers' Compensation coverage for all staff. Any injured staff member will be seen by Aspire's designated Industrial Injury Clinic or Medical Provider, unless informed otherwise by this pre-designation authorization.

If you would prefer to be seen by your own doctor for on-the-job injuries, you will need to have this form ***signed by your medical provider*** *and returned to the Human Resources Department.*

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.

Employee complete this section:

To **Aspire Public Schools**: 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): _____

Address: _____

Phone Number: _____

Employee Name (please print): _____

Employee's Signature: _____ Date _____

Physician: I agree to this Predesignation:

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

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