

Worker's Compensation Pre-designation Form
(For Selection of Personal Treating Physician)

In accordance with Labor Code section 4600, I hereby select my personal doctor to direct any and all medical treatment required in the case of an industrial injury.

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone #: _____

Employee's Signature

Date

Employee's Name: _____

Department; _____

Social Security #: _____

Work Phone #: _____

Complete this form and forward immediately to the SCVHHS Human Resources Department.
Keep a copy for yourself.