

**NOTICE OF PREDESIGNATION OF TREATING PHYSICIAN
OR MEDICAL FACILITY (8 C.C.R. §9783)**

Use this form to predesignate a treating physician or medical facility to protect your interests in the event you later experience a job-related injury or illness.

TO: *(Employer's Name)*

DOCTOR/MEDICAL GROUP PREDESIGNATED

If I experience a work-related injury or illness, I hereby choose to be treated by the following doctor (M.D./D.O.) or medical group:

NAME:

ADDRESS:

TELEPHONE NUMBER:

EMPLOYEE INFORMATION

NAME:

ADDRESS:

SIGNATURE:

DATE:

PHYSICIAN AGREEMENT

(To be completed by physician or designated employee of medical group.)

By signing below, I agree to the above predesignation.

SIGNATURE:

DATE: