

**SONOMA COUNTY OFFICE OF EDUCATION EMPLOYEE
PRE-DESIGNATED TREATING PHYSICIAN NOTIFICATION FORM**

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.) or doctor of osteopathic medicine (D.O.), per Labor Code Section 4600, 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;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses; and
- 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 the Sonoma County Office of Education 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 EMPLOYEE'S PREDESIGNATION OF A PERSONAL PHYSICIAN

Employee: Complete this section, please print

To: Sonoma County Office of Education

If I have a work-related injury or illness, I choose to be treated by:

Name of Physician, M.D. or D.O.: _____

Physician's Address: _____

Physician's Phone Number: _____

Employee's Name: _____

Employee's Address: _____

Employee's Signature: _____ Date: _____

TO BE COMPLETED BY PERSONAL PHYSICIAN

Physician: I agree to this Predesignation:

Physician's Signature: _____ Date: _____

Note: The physician is not required to sign this form, however, if the physician or designated employee of the physician 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).

EMPLOYEE: PLEASE RETURN COMPLETED FORM TO PATTI SPRINGER IN HUMAN RESOURCES

**SONOMA COUNTY OFFICE OF EDUCATION EMPLOYEE
NOTICE OF PERSONAL CHIROPRACTOR OR ACUPUNCTURIST**

*If you sustain a work-related injury or illness, SCOE's Insurer, Redwood Empire Schools Insurance Group (RESIG) requires you to initially treat with an Occupational Health Specialist, or your pre-designated personal physician (MD or DO); but may allow you to transfer care to your personal chiropractor or acupuncturist; if appropriate for your injury or illness. In order to do this, a **Notice of Personal Chiropractor or Acupuncturist** must be on file with the Sonoma County Office of Education prior to the date of your work-related injury or illness. You may use the form below for your notification.*

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness.

In order to be eligible to make this change you must:

- prior to the injury, provide your employer with the following in writing: your personal chiropractor's or acupuncturist's name, business address, and phone number.

Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with an Occupational Health Specialist or your pre-designated personal physician (MD or DO) during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

You may use this form to notify the Sonoma County Office of Education of your personal chiropractor or acupuncturist.

NOTICE OF EMPLOYEE'S PERSONAL CHIROPRACTOR OR ACUPUNCTURIST

Employee: Complete this section, please print

To: Sonoma County Office of Education

Name of Chiropractor or Acupuncturist _____

Address: _____

Phone Number: _____

Employee's Name: _____

Employee's Address: _____

Employee's Signature: _____ Date: _____

EMPLOYEE: PLEASE RETURN COMPLETED FORM TO PATTI SPRINGER IN HUMAN RESOURCES