

To: All Employees

From: Ron Owen, Sr. Benefits Analyst

Re: Third Party Administrator for Workers' Compensation and Form to Pre-Designate Your Personal Physician

The district is a member of the *Northern California Community College Self Insurance Agency* (NCCC SIA) for Workers' Compensation Coverage. As a result, attached are the required forms for pre-designating a personal physician to provide treatment for injuries that occur on the job through our Third Party Administrator, Keenan & Associates.

If you wish to designate a personal physician to treat you in the event of a workers' compensation injury, please complete the attached Physician Pre-Designation form. This form must be signed by you **AND** your personal physician and submitted to the Benefits Office, **BEFORE** an injury occurs, to be valid.

Please be advised that if you **DO NOT** wish to pre-designate a treating physician, you must seek treatment at the employer's designated facility for the first 30 days of your claim. In the event you have selected a new personal physician, but wish to seek treatment at the employer's designated facility, you may do so.

A pre-designated personal physician **MUST** meet **ALL** of the following requirements found in Labor Code Section 4600 (d) (1):

1. The personal physician you select must be your "regular physician and/or surgeon" who has your medical record file and history.
2. The physician must have previously directed your medical treatment.
3. The physician you select **MUST** agree to being pre-designated by you.

If you wish to designate a personal physician to treat you in the event of a workers' compensation injury, please complete the **Physician Pre-Designation form** and have your pre-designated physician complete and sign the *Personal Physician Acknowledgement*. **You will need to return the form to the Benefits Office.**

If you have any questions, please contact Ron Owen in the Benefits Office at (415) 884-3159.

MARIN COMMUNITY COLLEGE DISTRICT

Workers' Compensation: Pre-Designation of Personal Physician

If your employer offers group health insurance and you are injured on the job you have the right to be treated immediately by your personal physician (M.D., D.O) if you notify your employer, in writing, prior to the injury. Per Labor Code 4600 **to qualify as the your predesignated, personal physician, the physician must agree, in writing, to treat you for a work related injury,** must have previously directed your medical care and must retain your medical history and records. Your predesignated physician must be a family practitioner, general practitioner, board certified or board eligible internist, obstetrician-gynecologist, pediatrician or a multi-specialty medical group, whose practice is predominantly for non-occupational injuries or illnesses.

This is an optional form that can be used to notify your employer of your personal physician. You may choose to use another form, as long as you notify your employer, **in writing, prior** to being injured on the job and provide **written verification** that your personal physician meets the above requirements and agrees to be predesignated. Otherwise, you will be treated by one of your employers' designated workers' compensation medical providers.

EMPLOYEE NAME: _____

I acknowledge receipt of this form and elect not to predesignate my personal physician at this time. I understand that I will receive medical treatment from my employers' medical provider. I understand that, at any time in the future, I can change my mind and provide written notification of my personal physician. I understand that the written notification must be on file prior to an industrial injury.

Employee Signature: _____ Date: _____

If I am injured on the job, I wish to be treated by my personal physician*:

Name of Physician _____ Phone Number _____

Physician Address _____

*This physician is my personal primary care physician who has previously directed my medical care and retains my medical history and records.

Employee Signature: _____ Date: _____

A Personal Physician must be willing to be predesignated and treat you for a workers' compensation injury. The remainder of this form is to be completed by your physician and returned to your Employer.

PERSONAL PHYSICIAN ACKNOWLEDGEMENT

Per Labor Code 4600 to qualify you must meet the criteria outlined above. You are not required to sign this form, however, if you or your designated employee, does not sign, other **written** documentation of the physicians' agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

PERSONAL PHYSICIAN NAME: _____

I agree to treat the above named employee in the event of an industrial accident or injury. I meet the criteria outlined above. I agree to adhere to the Administrative Director's Rules and Regulations, Section 9785, regarding the duties of the employee-designated physician.

I do not agree to treat the above employee in the event of an industrial accident or injury.

I do not qualify as the employees' personal physician. I am not an M.D. or D.O. or do not meet the criteria outlined above.

Physician Signature

Date

**Please return completed form to:
Marin Community College District, Attention: Ron Owen, Senior Benefits Analyst
1800 Ignacio Blvd. Novato CA 94949 Fax (415) 883-3261**