LOS ANGELES COMMUNITY COLLEGE DISTRICT
STATEMENT OF EMPLOYEE'S PRE-DESIGNATED PHYSICIAN AND EMPLOYEE CONSENT

District Information
Los Angeles Community Colleges
Risk Management Department
770 Wilshire Boulevard, 3rd Floor
Los Angeles, CA 90017
Telephone: (213) 891-2397; (213) 891-2231
FAX: (213) 890-2490

Form Instruction
Section I: *Print Employee name, SSN, College or District department, and daytime telephone number. Employee signature and date required.*
Section II: *Print Physician name, clinic address and telephone number. Physician's signature is optional, but preferable.*
Section III: *District/Third Party Administrator verification/approval is required.*

SECTION I: EMPLOYEE CONSENT

EMPLOYEE NAME *(Print)*		**EMPLOYEE SSN:**	
COLLEGE/DEPT. *(Print)*		**TELEPHONE #**	

I hereby request that I be treated by my personal physician, as listed below, in the event of any occupational injury or illness. I understand that in the event of an emergency, I may be transported to the nearest emergency facility and not the physician listed below. I understand that in the event that I cannot provide transportation to my personal physician, the District will only transport me to a District authorized medical facility for treatment of occupational injuries and illnesses. I understand that if my personal physician is not available to treat me at the time medical attention is indicated, I must report for treatment at a District authorized medical facility. In absence of my physician's signature in Section II, by signing below, I attest that I have spoken with and confirmed with my physician that my physician meets the requirements of being pre-designated as outlined in Section II, agrees to be pre-designated, and agrees to treat and/or direct treatment for occupational injuries and illnesses. If it is determined that my physician does not meet the requirements of being pre-designated or did not agree to be pre-designated or is unwilling to treat occupational injuries and illnesses, I understand that I must report for treatment at a District authorized medical facility.

EMPLOYEE'S SIGNATURE		**DATE SIGNED**	

SECTION II: PHYSICIAN'S STATEMENT

I/We have directed the medical treatment for the above listed individual in the past and retain the medical records and medical history for this individual. Furthermore, I/We agree to provide all necessary and reasonable medical treatment to this individual in the event of an occupational injury or illness sustained by the individual while employed with the Los Angeles Community College District. I/We agree to abide by the Administrative Director's rules and regulations as stated in Title 8, California Code of Regulations, Section 9785, *Duties of the Employee-Selected Physician.*

PHYSICIAN NAME *(Print)*		**PHYSICIAN'S SIGNATURE**	
PHYSICIAN ADDRESS *(Print)*		**PHYSICIAN'S TELEPHONE**	

SECTION III: DISTRICT/THIRD PARTY ADMINISTRATOR VERIFICATION/APPROVAL

RECEIVED BY: *(Print)*		**DATE RECEIVED**	
VERIFIED BY: *(Print)*		**DATE APPROVED**	

REFERENCES: **EH&S RR-03-5**
8 CCR §9785 et seq

REVISED 08/06

****PLEASE KEEP A COPY FOR YOUR RECORDS****

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SECTION I: INSTRUCTIONS AND INFORMATION FOR EMPLOYEES

Should you become ill or injured on the job, you are entitled to first aid or emergency medical treatment, as necessary. Emergency medical treatment is medical treatment reasonably required by an injured employee immediately following an occupational injury or illness, which, if delayed, could decrease the likelihood of maximum recovery.

You are required to report all occupational injuries or illnesses to your onsite supervisor. At that time, you should be provided with the DWC Form 1*, Employee's Claim for Workers' Compensation Benefits*. If you are not provided this form, please telephone the District's Risk Management Department at (213) 891-2397. A DWC Form 1, *Employee's Claim for Workers' Compensation Benefits,* will be immediately mailed to your residence.

If you have not pre-designated your personal physician in writing prior to the date of this occupational injury or illness, then your initial medical treatment will be directed by a physician and facility authorized by the District. The form detailing these locations and telephone numbers will be provided to you. Please take this form with you when reporting for your initial treatment. Within the first thirty (30) days following the date the occupational injury or illness was first reported, you may request an alternate physician from the District's Third Party Administrator and the request shall be honored within five (5) days. After thirty (30) days from the date the occupational injury or illness was first reported, you may change your treating physician to one of your own choosing by notifying, in writing or by telephone, the District's Risk Management Department at (213) 891-2231 or the District's Third Party Administrator at (818) 997-3500.

If you have pre-designated your personal physician prior to the date of this occupational injury or illness, then your initial medical treatment may be directed by your personal physician or you may report for treatment at an authorized District facility. For the purpose of utilizing an employee-selected physician, initial medical treatment does not include first aid or emergency medical treatment. If you are in need of transportation from work in order to receive treatment, you may only be transported to an authorized District facility. Your onsite supervisor is responsible to coordinate any needed transportation.

SECTION II: INSTRUCTIONS AND INFORMATION FOR PHYSICIANS

CAUTION: If you are the employee's personal physician who undertakes to provide treatment pursuant to Labor Code Section 4600 for occupational injuries and illnesses, you must adhere to the filing, reporting, and time requirements specified in Title 8 California Code of Regulations Section 9785, *Duties of the Employee-Selected Physician.*

The Los Angeles Community College District is a self-insured employer. **Within three (3) working days** after undertaking to provide initial treatment, you must notify the District's Third Party Administrator (TPA) of the name and address of the treating physician or facility, unless already listed as a District authorized health care facility. **Within five (5) working days** of your initial examination for every occupational injury or illness, you must send two (2) copies of the completed State of California Form 5021, *Doctor's First Report of Occupational Injury or Illness*; one copy to the District and one copy to the District's TPA. Where the employee has been exposed to bloodborne pathogens, regulated carcinogens, or toxic substances, you are required to provide the District and the District's TPA with your written opinion in accordance with any applicable Section of Title 8, California Code of Regulations for the specific substance within fifteen (15) days of your completed evaluation. All required reports and correspondence are to be sent to the District and the District's TPA. For timely payment, you may send invoices directly to the District's TPA.

DISTRICT
LOS ANGELES COMMUNITY COLLEGE DISTRICT
770 WILSHIRE BLVD., 3RD FLOOR
LOS ANGELES, CA 90017
ATTN: RISK MANAGEMENT DEPARTMENT

TELEPHONE: (213) 891-2397

TELEPHONE: (213) 891-2231
Fax: (213) 891-2490

THIRD PARTY ADMINISTRATOR (TPA)
SOUTHERN CALIFORNIA RISK MANAGEMENT ASSOCIATES
3313 EAST FOOTHILL BOULEVARD
UPLAND, CA 91786

TELEPNONE: (909) 608-7171

FAX: (909)608-7165

REFERENCES: **EH&S RR-03-5**
8 CCR §9785 et seq

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