LONG BEACH UNIFIED SCHOOL DISTRICT
STATEMENT OF EMPLOYEE'S PRE-DESIGNATED PHYSICIAN AND EMPLOYEE CONSENT

District Information

Long Beach Unified School District
Business Department – Financial Services
Risk Management Branch
Workers' Compensation Office
1515 Hughes Way
Long Beach, CA 90810
Telephone: (562) 997-8231
Telephone: (562) 997-8235
Fax: (562) 997-8052

Form Instructions

Section I: *Employee - print name, SSN, work site and work telephone number*
Section II: *Physician - print name, clinic address and telephone number. Physician's signature is required for processing.*
Section III: *Employee signature and date required. Return form to the District's Workers' Compensation Office.*
Section IV: *District approval is required.*

SECTION I ADMINISTRATIVE (Employee)

EMPLOYEE NAME (Print)		**EMPLOYEE SSN or ID No.:**	
WORK SITE (Print)		**WORK/TELEPHONE**	

SECTION II PHYSICIAN'S STATEMENT (Physician)

I 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 understand my obligation to provide all necessary and reasonable medical treatment to this individual in the event of an on-the-job injury or illness sustained by the individual while employed with the Long Beach Unified School District per the Administrative Director's rules and regulations as stated in Section 9785, *Duties of the Primary Treating Physician.*

Pursuant to Section 4600 (d) (5) of the Labor Code, the District may require prior authorization of any non-emergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to Section 4610.

PHYSICIAN NAME (Print)		**PHYSICIAN SIGNATURE** (Sign)	
CLINIC ADDRESS (Print)		**CLINIC TELEPHONE**	

SECTION III EMPLOYEE CONSENT (Employee)

Per section 4600 (d) (2) of the Labor Code, an employee may pre-designate his or her personal physician provided:
A. The physician is the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.
B. The physician is the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.
C. The physician agrees to be pre-designated.

I hereby request that I be treated by my personal physician, as listed above, in the event of any occupational injury or illness.

EMPLOYEE SIGNATURE (Sign)		**DATE SIGNED**	

SECTION IV DISTRICT VERIFICATION (Risk Management Branch – Workers' Compensation Office)

RECEIVED BY:		**DATE RECEIVED**	

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SECTION III: 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 that 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 shall report all occupational injuries or illnesses to your onsite supervisor. In the event that the injury or illness requires medical treatment beyond "first aid" or results in "lost time" beyond the date of injury, the District must provide you with the Workers' Compensation Claim Form (DWC 1). "First aid" means any one-time treatment, and any follow-up visit for the purpose of observation of minor scratches, cuts, burns, splinters, etc., which do not ordinarily require medical care. Such one-time treatment and follow-up visit for the purpose of observation, is considered first aid, even though provided by a physician or registered professional personnel. "Lost time" means absence from work for a full day or shift beyond the date of injury or illness. You should have received DWC Form 1 at the time you reported the injury to your supervisor. If you did not receive this form or if the injury or illness subsequently requires medical treatment beyond first aid or results in lost time, please telephone the District Workers' Compensation Office. A Workers' Compensation Claim Form (DWC 1) will be immediately mailed to your home of residence.

If you have not pre-designated your personal physician in writing prior to the date of this occupational injury or illness, then your medical treatment will be directed by a physician and facility authorized by the District. 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 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 Workers' Compensation Office or Third Party Administrator only if the District has not established a Medical Provider Network.

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 the appropriate authorized District location. For the purpose of utilizing an employee-selected physician, initial medical treatment does not include first aid or emergency medical treatment.

SECTION IV: 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 follow all of the filing, reporting, and time requirements specified in the Administrative Director's rules, Section 9785, *Reporting Duties of the Primary Treating Physician.*

The Long Beach Unified School District is a self-insured employer with Third Party Administrator (TPA). **Within three (3) working days** after undertaking to provide initial treatment, you must notify the 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 TPA. Where the employee has been exposed to bloodborne pathogens, regulated carcinogens, or toxic substances, you are required to provide the District and 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. Send all required reports and correspondence to the District and TPA. For timely payment, you may send invoices directly to the TPA.

DISTRICT
LONG BEACH UNIFIED SCHOOL DISTRICT
1515 HUGHES WAY
LONG BEACH, CA 90810
ATTN: WORKERS' COMPENSATION OFFICE
TELEPHONE: (562) 997-8231
FAX: (562) 997-8052

THIRD PARTY ADMINISTRATOR (TPA)
TRISTAR RISK MANAGEMENT
P.O. BOX 512028
LOS ANGELES, CA 90051
TELEPHONE: (562) 506-0300
FAX: (562) 981-0804

CAUTION: Failure to file any of the required reports may result in assessment of a civil penalty.