Department of Fish and Game
Human Resources Branch

WORKERS' COMPENSATION PRE-DESIGNATION FORM

If I am injured on the job, I wish to be treated by my regular personal physician **OR** personal medical group; who is my primary care physician or medical treatment group, has previously directed my medical treatment and retains my medical treatment records.

EMPLOYEE'S INFORMATION: (Please type or print)

____

Last Name | First Name | Middle Initial

DOCTOR *OR* MEDCIAL GROUP INFORMATION: (Please type or print)

____

Name of the Doctor or Medical Group

____

Address | **Telephone**

____

City | **State** | **Zip Code**

Signatures:

____

Employee's Signature (Required) | **Date**

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Doctor's or Medical Group Representative's Signature (Required) | **Date**

Original to: Employee's Official Personal File (OPF)
Copies to: Employee & employee's immediate supervisor at time of change or completion
Copy to: HRB/Workers' Comp Unit ***ONLY*** at time of injury

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