

PERSONAL PHYSICIAN FORM

To: _____

In the event that I sustain a job-related illness or injury, I designate my personal physician to provide medical care immediately after the injury, and for the purpose of all related care, as appropriate, for the duration of my treatment for that illness or injury. By making this request I am not waiving my right to immediate, appropriate and adequate emergency medical treatment in instances where my personal physician is unavailable, nor am I waiving my right to be referred to specialists or other providers as necessary.

Personal Physician: _____
(Physician's Name, Office, Clinic or Hospital)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Signature of Acknowledgment: _____
(By Physician Office, Clinic, or Hospital)

Employee's Signature: _____

Employee's Name (print): _____

Date: _____