

# SOUTHWEST AIRLINES

## EMPLOYEE PRE-DESIGNATION OF PERSONAL PHYSICIAN

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The California Labor code grants an employee who has sustained an occupation injury or illness, the right to medical care. Labor Code Sec, 4600 (d) permits you, the employee, the right to be treated by a "person physician" if the physician is designated prior to the injury or illness. A personal physician must meet all of the following conditions:

1. The physician is your regular physician licensed as an M.D. or D.O.
  2. The physician is your primary care physician and has previously directed your medical treatment and who retains your medical records, including your medical history.
  3. The physician agrees to be pre-designated and agrees to follow requirements of the treating physician as stated in Title 8, CCR Sec 9785. A copy of Sec. 9785 is attached and is to be given to your physician when he/she this form.
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### PLEASE TYPE OR PRINT CLEARLY:

Employee Name: \_\_\_\_\_ Payroll: # \_\_\_\_\_

Employee Health Care Plan: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City: \_\_\_\_\_ State: Ca Zip: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_

This document identifies my personal primary care physician. In event a job-related injury or illness occurs after the date of this notification and during the course of (my employment with personal primary care physician as of the date of injury. I understand that personal physician means "my regular physician and surgeon, licensed pursuant to Chapter 5 ) commencing with Section 2000) of Division 2 of the Business and Professions code (this does include chiropractors or acupuncturists) who has previous directed my medical treatment and who retains my medical records, including my medical history."

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### ACKNOWLEDGMENT OF PERSONAL PHYSICIAN:

I hereby agree to be the designated treating physician for the above employee in the event of a work-related injury or illness. I agree to follow the requirements of the treating physician as outlined I Title 8 CCR Sec 9785 and have received a copy of the requirements. I further certify that I am the employee's regular primary care physician, have previous directed his/her medical treatment and retain their medical records including medical history.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_