

**EMERGENCY INFORMATION / PHYSICIAN DESIGNATION**

Office of Human Resources

DGS OHR 20 (Rev. 7/14)

**CONFIDENTIAL**

Please submit completed forms to your supervisor. Supervisors will retain the original and forward a copy to the Office of Human Resources for inclusion in your official personnel file. Submit a new form to your supervisor immediately when information listed below changes. If you have a chronic medical problem (i.e. a heart condition, epilepsy, asthma, diabetes, etc.) that could incapacitate you during work hours, you are encouraged to discuss symptoms and emergency treatment with your supervisor.

**EMERGENCY INFORMATION*****Please Print or Type***

EMPLOYEE NAME (Last, First, Middle Initial)		HOME TELEPHONE NUMBER	
HOME ADDRESS (Number and Street)	(City, State)	(Zip Code)	
		MOBILE PHONE NUMBER	
OFFICE	UNIT	BIRTHDATE	
Person(s) to notify in case of accident or illness	NAME	RELATIONSHIP	
	ADDRESS	TELEPHONE NUMBER	
	CITY, STATE	ZIP CODE	
			MOBILE PHONE NUMBER
	NAME	RELATIONSHIP	
	ADDRESS	TELEPHONE NUMBER	
CITY, STATE	ZIP CODE	MOBILE PHONE NUMBER	

**PHYSICIAN DESIGNATION**

In case of injury of sudden job-related illness, employees are given the option of choosing their own personal physician to administer medical treatment or accepting services provided by the department. "Personal Physician" means the employee's regular physician and surgeon who has previously directed the medical treatment of the employee and who retains the employee's medical records. The physician is not required to sign this form, but in lieu of a signature, other documentation of the physician's agreement is required.

- I decline designating a personal physician AND will accept medical treatment from the department's designated medical facility.
- If I am injured on the job, I wish to be treated by my personal physician or my personal physician's integrated multi-specialty medical group, who meets all the following requirements: (1) is my regular physician; (2) is my primary care physician or integrated multi-specialty medical group; (3) is licensed per Business & Professions Code; (4) has previously provided my treatment; (5) retains my records; (6) agrees to be my pre-designated physician.

PHYSICIAN'S NAME AND/OR NAME OF PERSONAL PHYSICIAN'S MULTI SPECIALTY MEDICAL GROUP	TELEPHONE NUMBER
OFFICE ADDRESS	
HOSPITAL PREFERENCE	HEALTH PLAN/ID NUMBER


**EMPLOYEE'S SIGNATURE****DATE SIGNED**

I am the above employee's regular, primary care physician. I have previously treated and do retain his/her medical records and I agree to treat the above employee for a work related injury and/or illness.


**PHYSICIAN'S SIGNATURE** or designated employee of the physician's medical group**DATE SIGNED**