

Wm. Bolthouse Farms/TMC MEDICAL PROVIDER NETWORK (MPN)

Employee Physician Pre-Designation Form

If I am injured on the job, I request to be treated by my personal physician, who has treated me before and has my medical treatment records.

(Employer Name)

(Department)

Employee Information:

(Employee's Name – Please PRINT)

(Employee's Date of Birth)

(Employee's Date of Hire)

I understand that my physician must agree to act as my Primary Treating Provider under my employer's workers' compensation program for my work-related injury. In the event the above named physician is not appropriate to treat my work-related injury or does not to agree to act in this capacity, I will be required to seek care with an MPN physician.

I agree to the above conditions, and will return the completed form to my employer.

(Employee's Signature)

(Date)

Your Doctor's Information:

(Doctor's Name – Please PRINT)

(Doctor's Federal Tax ID Number)

(Doctor's Specialty)

(Doctor's Telephone Number)

(Doctor's Address)

I hereby certify that I am the above named employee's regular physician, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code. I have personally directed the medical treatment of this employee, and I retain this employee's medical records, including his or her medical history. I agree to be pre-designated as this employee's physician in the event of an industrial injury or illness.

(Doctor's Signature)

(Date)

(Note to Employer: Retain the completed form in employee's personnel file and forward a copy to the TMC MPN Coordinator.)