Predesignation of Personal Physician

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your HMO medical doctor if:

- Prior to the injury you provided your employer the following in writing: (1) notice that you want your doctor to treat you for a work-related injury or illness, and (2) your doctor's name and business address.
- Your doctor agrees to follow the Texas Workers Compensation Healthcare Network requirements

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work- related injury or illness and the above requirements are met.

Employee: Complete this section.

To: _____
(name of employer).

If I have a work-related injury or illness, I choose to be treated by:

_____
(Name of doctor) (M.D., D.O.)

_____
(Street address, city, state, ZIP)

_____
(Telephone number)

Employee Name (please print): _____

Employee's Address:_____

Employee's Signature _____Date:_____

Physician: I agree to this Predesignation:

Signature: _____Date:_____
(Physician or Designated Employee of the Physician)

The physician is not required to sign this form, however, if the physician or designated employee of the physician does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Insurance Code §§ 1305.105 §1305.005 and 1305.451.

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