# Employee Physician Pre-designation Form

I acknowledge receipt of my employer's notice of its approved medical provider network (MPN) for any work-related injuries I may have in the future. ______
{Initial}

At this time, I wish to use my own "pre-designated" physician(s) and affirm the provider has treated me in the past. The physician(s) include the following: (**Use additional pages if necessary.)

| | |
|---|---|
| ___________________________<br>{Physician's Name} | ___________________________<br>{Physician's Name} |
| ___________________________<br>{Physician's Address} | ___________________________<br>{Physician's Address} |
| ___________________________<br>{Physician's Address} | ___________________________<br>{Physician's Address} |
| ___________________________<br>{Physician's Telephone} | ___________________________<br>{Physician's Telephone} |
| ___________________________<br>{Specialty} | ___________________________<br>{Specialty} |

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 physicians are not appropriate to my work-related injury or do not agree to act in this capacity, I will be required to seek care with an MPN physician.

____
{Initial}

I agree to the above conditions and have had an opportunity to ask questions.

_____________________________ _____________________
{Signature} {Date}

_____________________________
{Print Full Name}