



- ☐ **Anaheim Main Campus:** 1126 N. Brookhurst St., Anaheim, CA 92801-1701
Tel: 714-533-1495 Fax: 714-533-6040
- ☐ **Los Angeles Campus:** 2727 W. 6th St., Los Angeles, CA 90057-3139
Tel: 213-738-0712 Fax: 213-480-1332

STATEMENT OF PERSONAL PHYSICIAN

If you are injured on the job when we do not have this form in the file, we will send you to a doctor of our choice.

If you wish to be treated by your physician in the event of an on-the-job injury, fill out this form and return it with the rest of the required paperwork.

Name of Employee: _____
last first middle

A. IF I AM INJURED ON THE JOB, I WISH TO BE TREATED BY MY PERSONAL PHYSICIAN, WHO HAS TREATED BEFORE AND WHO HAS MY MEDICAL RECORDS.

Name of Doctor: _____
last first middle

Address: _____
Number Street City State Zip Code

Phone: _____

B. IF I AM INJURED ON THE JOB, I WISH TO BE TREATED BY THE PHYSICIAN ASSIGNED BY SBU.

Signature of Employee:

Date: