CARLSON HOME INSTRUCTIONAL PROGRAM AND HOSPITAL SCHOOL
EMPLOYEE PERSONAL PHYSICIAN DESIGNATION FORM

In the event of injury, in order to be treated by your own physician, the **Employee Personal Physician Designation Form** must be on file in the Carlson Home Instructional Program and Hospital School office.

EMPLOYEE PERSONAL PHYSICIAN DESIGNATION FORM

TO: LOS ANGELES UNIFIED SCHOOL DISTRICT

FROM: ______________________________ EMPLOYEE NUMBER: _________________

DATE: _______________________________ MAIL SITE: ___________________________

In the event I am injured or taken ill on the job, I reserve the right to be treated by my own physician and/or chiropractor from the time of my injury or illness.

MY PHYSICIAN'S NAME IS: ____

____
Street Address

____
City State Zip Code

(___________)____________________________________
Area Code Telephone Number

❒ PLEASE CHECK HERE TO REQUEST A COPY OF THIS FORM TO ACKNOWLEDGE ITS RECEIPT IN THE CHIPAHS OFFICE.

RECEIVED BY: ____DATE: ___________________
Carlson Home Instructional Program and Hospital School

7/05