



Chaffey College

CERTIFICATION OF PERSONAL PHYSICIAN

Date: _____

Name of Physician: _____

Address: _____

City/Zip Code: _____

Name of Employee: _____

This is to certify that _____ (employee) is a patient of mine. I have treated him/her for non-work related medical problems and I maintain his/her medical records in my office.

I am willing to take responsibility for following rules required of a Treating Physician, pursuant to California Code of Regulations, Title 8, Section 9785, when treating this employee for work-related injuries or illnesses. I acknowledge all requests for medical care will be governed by Labor Code 4610 outlining mandatory utilization review under the guidelines of the American College of Occupational and Environmental Medicine (ACOEM).

Physician's Signature: _____

Print Name: _____

Date: _____

I decline the request of _____ (employee) to be his/her Treating Physician for work-related injuries:

Physician's Signature: _____

Print Name: _____

Date: _____