



NOTICE OF PERSONAL PHYSICIAN PRE-DESIGNATION

TO: SOUTHERN CALIFORNIA GAS COMPANY HEALTH MANAGEMENT SERVICES, M.L. 16C0.
The physician listed below will treat me for an industrial injury if I do not elect to use one of the Company provided facilities. I understand I may list one physician only. The doctor listed below has treated me in the past and retains my medical records.

Name of Doctor: _____

Doctor's Address: _____

Doctor's Telephone Number: _____

Name (Please Print and Sign): _____

Employee I.D.#: _____

Employee's Signature: _____

Date: _____

I, Dr. _____, agree to treat the above named employee for his/her workers' compensation injury/ies.

Signature of Doctor

Received by: _____

Date: _____

Return this form to your supervisor, who will forward it to the Company's Workers' Compensation Department, Health Management Service., M. L. 16C0.