

NAME: _____

EMPLOYEE DESIGNATED PERSONAL PHYSICIAN

In the event of a work related injury, I choose to be treated by my personal chiropractor. I understand that my physician meets all the requirements under the California Labor Code to qualify.

Physician's Name: Mathew A. Snider, Sr., D.C.

OR

Mathew A. Snider, Jr., D.C.

Address: 481 S. Murphy Ave.
Sunnyvale, Ca. 94086

Telephone: (408) 736-7777

Employee Signature: _____

Date: _____

TO BE COMPLETED BY PERSONAL PHYSICIAN

I meet all the requirements under Labor Code 4600 to be this employee's personal physician. I will provide a Doctor's First Report of Injury (Form 5021) and supplemental medical reports as required by the Labor Code. I will accept payment of my services in accordance with the Official Medical Fee Schedule.

Physician's Signature: _____

Date: _____