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**Designation of Personal Physician Form**

**In the Event of Occupational Injury**

I, \_\_\_\_\_, hereby designate Dr. David Schechter as my physician in the event that I am injured at work and require treatment. I have seen him as my personal physician and he has records of my prior treatment.

I understand that I need to deliver the original of this signed form to my employer's Human Resources Department or Work Comp Manager. I will fax or mail a copy to the doctor's office. I will also keep a copy for myself.

Signature\_\_\_\_\_ Date \_\_\_\_\_