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 Snider, Jr., DC**
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 the 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: _____