HUMAN RESOURCES
550 E. Hospitality Lane Suite 200
San Bernardino, CA 92408
www.sbccd.edu

AUTHORIZATION FOR MEDICAL TREATMENT

Employee Name: _____ Campus/Department: _____

Date of Injury/Illness: _____ Time of Injury/Illness: _____ ☐ AM ☐ PM

Job Title: _____ Supervisor Name: _____

IMPORTANT – CHOOSE ONE OPTION LISTED BELOW:

☐ **I Accept** medical treatment at a clinic designated by the San Bernardino Community College District as listed below. ***Please select one of the clinics below by checking the appropriate box.***

☐ **I Decline** medical treatment at this time. Additionally, I understand that if i should need medical treatment at a later date I will notify my supervisor and human resources.

☐ I choose to be treated by the **Pre-Designated Physician**. I understand that this physician signed designation must be on file with human resources ***prior*** to the date of this injury.

√	NAME	ADDRESS	PHONE	HOURS
☐	COMP – CENTRAL OCCUPATIONAL MEDICINE PROVIDERS	295 E. CAROLINE ST., STE D1 SAN BERNARDINO, CA 92408 **OTHER LOCATIONS AVAILABLE**	909-723-1161	9:00 AM TO 6 PM MON-FRI ON-CALL SAT-SUN
☐	REDLANDS INDUSTRIAL MEDICINE CLINIC	255 TERRACINA BLVD. SUITE 101-A REDLANDS, CA 92373	909-748-6569	9:00 AM TO 6:45 PM MON-FRI 10:00 AM TO 4:45 PM SAT
☐	HEALTHPOINTE	290 N. 10TH ST., #100 COLTON, CA 92324	909-264-2500	24 HOURS / 7 DAYS A WEEK

Employee Signature: _____ Date: _____

Authorizing Supervisor Name (Print): _____ Title: _____

Authorizing Supervisor Signature: _____ Date: _____

Instructions for Medical Provider:

Mail Original Doctor's First Report and All Medical Bills To:

First Aid Claims Only:
SBCCD, ATTN: HUMAN RESOURCES
550 E. HOSPITALITY LANE SUITE 200
SAN BERNARDINO, CA 92408

Recordable Claims:
KEENAN & ASSOCIATES
PO BOX 59916
RIVERSIDE, CA 92517
951-715-0190
951-788-8013 (fax)

Distribution:

Original: Medical Provider Copy: Fax to SBCCD HR 909-387-1103 Copy: Employee