

FORM C-42

TENNESSEE
BUREAU OF WORKERS' COMPENSATION



**EMPLOYEE'S
CHOICE OF PHYSICIAN**
Medical Panel

Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed, signed version of this form on file and send a copy to the employee for their records.
 - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
 - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
 - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE EMPLOYER:

Employee Name _____ Date Panel Provided _____

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

<p>Physician Option 1 Name _____ Phone _____</p> <p>Address _____ City _____ State _____ Zip _____</p> <p>Is Telehealth available? Yes ___ No ___ If yes, web address _____</p>
<p>Physician Option 2 Name _____ Phone _____</p> <p>Address _____ City _____ State _____ Zip _____</p> <p>Is Telehealth available? Yes ___ No ___ If yes, web address _____</p>
<p>Physician Option 3 Name _____ Phone _____</p> <p>Address _____ City _____ State _____ Zip _____</p> <p>Is Telehealth available? Yes ___ No ___ If yes, web address _____</p>
<p>(Optional) Telehealth-Only Physician 4 Name _____ Phone _____</p> <p>Telehealth Provider email address _____ Web address _____</p>

TO BE COMPLETED BY THE EMPLOYEE:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ___ **or** Treatment by Telehealth ___ Were you offered in-person treatment? Yes ___ No ___

Employee Signature _____ Date _____