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 original 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 ________________

Physician 1	**Physician 2**	**Physician 3**
Name ____________	Name ____________	Name ____________
Phone ____________	Phone ____________	Phone ____________
Address ____________	Address ____________	Address ____________
____________	____________	____________
City ____________	City ____________	City ____________
State ______ Zip ______	State ______ Zip ______	State ______ Zip ______
Is Telehealth available with Physician #1? Yes ____ No ____	Is Telehealth available with Physician #2? Yes ____ No ____	Is Telehealth available with Physician #3? Yes ____ No ____
If yes, web address	If yes, web address	If yes, web address
____________	____________	____________

(Optional) Telehealth-Only **Physician 4** Name ____________________ Phone ____________

Telehealth Provider email address ____________________ Web address ____________________

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 ______________