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 _____

Physician Option 1 Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Is Telehealth available? Yes ☐ No ☐ If yes, web address _____

Physician Option 2 Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Is Telehealth available? Yes ☐ No ☐ If yes, web address _____

Physician Option 3 Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Is Telehealth available? Yes ☐ No ☐ 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 _____

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