

## Tennessee Bureau of Workers' Compensation 220 French Landing Drive, I-B Nashville, TN 37243-1002

**FORM C-42** 

## EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. NOTE: Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

## TO BE COMPLETED BY THE EMPLOYER:

Employer		Date of Injury _	
Employer Contact	Phone	Email	
Physician Name		Phone	
Address	City	State	Zip
Physician Name		Phone	
Address	City	State	Zip
Physician Name		Phone	
Address	City	State	Zip
TO BE COMPLETED BY TH	IE EMPLOYEE:		
I have selected the following physicia	an from the list provided to me by my	employer:	
Physician Name		Date Selected	
Employee Name		Appt Date/Time	
Address	City	State	Zip
Phone	Email		
Employee Signature		Date	

LB-0382 (REV 11/15) RDA 10183