

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