

**FORM C-42**

**Tennessee Bureau of Workers’ Compensation 220 French Landing Drive, I-B**

**Nashville, TN 37243-1002**

# 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 Saint Thomas Hospital (Dr. Ronald E. McFarland) Phone 615-329-7200

Address 2004 Hayes St.

City Nashville

State \_TN

Zip 37203

Physician Name Tennessee Retina (Dr. Everton Arrindell) Phone 615-983-6000

Address 345 23rd Ave N #350

City Nashville

State \_TN

Zip 37203

Physician Name Eye Centers of Tennessee (Dr. James Grisolano) Phone 731-424-2414

Address 668 Skyline Drive

City Cookeville

State \_TN

Zip 38301

# TO BE COMPLETED BY THE EMPLOYEE:

**I have selected the following physician 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