

**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 My Eye Doctor

Phone 731-286-2744

Address 400 US Highway 51 Bypass W City Dyersburg

State \_TN

Zip 38024

Physician Name Cape Regional Eye Center Phone 731-286-2801

Address 401 Tickle St. E

City Dyersburg

State \_TN

Zip 38024

Physician Name Dyersburg Regional Medical Center Phone 731-285-2410

Address 400 Tickle Street

City Dyersburg

State \_TN

Zip 38024

# 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