

**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 Wound Care at St. Francis Hospital- Bartlett Phone 901-382-6280

Address 2986 Kate Bond Rd

City Bartlett

State \_TN

Zip 38133

Physician Name North Wound Healing Center Phone 901-516-5766

Address 3950 New Covington Pike, Suite 350 City Memphis

State \_TN

Zip 38128

Physician Name Baptist Memorial Restorative Care Phone 901-226-4200

Address 6019 Walnut Grove Road

City Memphis

State \_TN

Zip 38120

# 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

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