

**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 Dr. William Garrison Strickland Phone 615-284-2214

Address 300 20th Ave. North, Suite 600 City Nashville

State \_TN

Zip 37203

Physician Name Dr. Richard Rubinowicz Phone 615-355-5510

Address 301 Quecreek Circle

City Smyrna

State \_TN

Zip 37167

Physician Name Dr. Daniel Donovan Phone 931-528-5811

Address 105 Cherry Avenue

City Cookeville

State \_TN

Zip 38501

# 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