

## 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 Rogersville Medical Complex (Dr. Mark Dalle-Ave) Phone 423-921-1600

Address 4307 TN-66, Suite #4 City Rogersville State TN Zip 37857

Physician Name Healthstar (Dr. Eric Delay) Phone 423-581-2538

Address 420 W Morris Blvd #400g City Morristown State TN Zip 37813

Physician Name Bulls Gap Medical Center (Dr. Mark Doman) Phone 423-235-4191

Address 260 US-11E City Bulls Gap State TN Zip 37711

# 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