

**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 University Wound Care & Hyperbaric Center Phone 865-305-9000

Address Bldg E, Ste. E-40, 1940 Alcoa Highway City Knoxville

State TN

Zip 37920

Physician Name Tennova Wound Care Center Phone 865-218-7525

Address 10820 Parkside Drive

City Knoxville

State \_TN

Zip 37934

Physician Name Johnson City Medical Center Phone 423-431-2650

Address 408 N. State of Franklin Rd., Ste. 12 City Johnson City

State \_TN

Zip 37604

# 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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