FORM C-42

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Division of Workers' Compensation
Nashville, Tennessee 37243-0661
Website: www.state.tn.us/labor-wfd/wcomp.html
Telephone: 1-800-332-2667

EMPLOYEE'S CHOICE OF PHYSICIAN

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

State File Number: ______________________ Date of Injury: ______________________

Employee: ______________________ SSN: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Employer: ______________________ FEIN: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

PANEL OF PHYSICIANS

Tennessee Code Annotated §50-6-204(a)(4)(A) requires an employer to offer a panel of three physicians to the injured employee. If the injury is a back injury the panel must be expanded to four, one of whom must be a chiropractor. Chiropractor visits are limited to 12 visits per back injury. The injured employee must select a physician from the panel.

Physicians Name: ______________________ Phone: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Is Physician a Specialist? ☐ Yes ☐ No If yes, give specialty: Ortho, Neuro, Chiro, etc. ______________

Physicians Name: ______________________ Phone: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Is Physician a Specialist? ☐ Yes ☐ No If yes, give specialty: Ortho, Neuro, Chiro, etc. ______________

Physicians Name: ______________________ Phone: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Is Physician a Specialist? ☐ Yes ☐ No If yes, give specialty: Ortho, Neuro, Chiro, etc. ______________

Physicians Name: ______________________ Phone: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Is Physician a Specialist? ☐ Yes ☐ No If yes, give specialty: Ortho, Neuro, Chiro, etc. ______________

Physicians Name: ______________________ Phone: ______________________

Address: ______________________ City: ____________ State: ________ Zip: ________

Is Physician a Specialist? ☐ Yes ☐ No If yes, give specialty: Ortho, Neuro, Chiro, etc. ______________

I hereby have selected the following physician from the list provided to me by my employer:

Physician Chosen: ____

Employee Signature: ______________________ Date Selected: ______________________

A copy of this form must be provided to the employee. The employer must keep the original form on file and upon request provide a copy to the Division of Workers' Compensation.

This form is required to be in compliance with Tennessee Code Annotated §50-6-204.