FORM C-42

TENNESSEE
BUREAU OF WORKERS' COMPENSATION

EMPLOYEE'S CHOICE OF PHYSICIAN
Medical Panel

Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
  - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
  - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
  - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE **EMPLOYER:**

Employee Name _____ Date Panel Provided _____

Employer Murfreesboro City School Date of Injury _____

Employer Contact Maria Winfree Phone 615-893-2313 Email maria.winfree@cityschools.net

Physician 1	**Physician 2**	**Physician 3**
Name Dr. Todd Wise	Name Dr. Charles Tessier	Name Dr. Chrisopher Ingraham
Phone 615-410-4099	Phone 615-439-6165	Phone 615-217-6900
Address Care Now Urgent Care	Address Hometown Family Medical	Address Urgent Team--Murfreesboro
2105 Memorial Blvd, Suite B	1346 Dow Street	2445 Memorial Blvd, Suite C
City Murfreesboro	City Murfreesboro	City Murfreesboro
State TN Zip 37129	State TN Zip 37130	State TN Zip 37129
Is Telehealth available with Physician #1? Yes ☐ No ☒	Is Telehealth available with Physician #2? Yes ☐ No ☒	Is Telehealth available with Physician #3? Yes ☐ No ☒
If yes, web address _____	If yes, web address _____	If yes, web address _____

(Optional) Telehealth-Only **Physician 4** Name _____ Phone _____

Telehealth Provider email address _____ Web address _____

TO BE COMPLETED BY THE **EMPLOYEE:**

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

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ☐ **or** Treatment by Telehealth ☐ Were you offered in-person treatment? Yes ☐ No ☐

Employee Signature _____ Date _____