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

A panel of three physicians is required. If the injury is a back injury the panel must be expanded to four, one of whom must be a chiropractor. Chiropractor visits may be authorized for up to twelve (12) visits per back injury. More than twelve (12) visits to such doctor of chiropractic must be specifically approved by the employer or insurance carrier. The injured employee must select a physician (or chiropractor) 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.

LB-0382 (rev. 8/05)