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, signed version of this 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 __Blount County Government_____ Date of Injury _____

Employer Contact __Lindsey Jackson_____ Phone __865-273-5771__ Email __ljackson@blounttn.org__

Physician Option 1 Name __Dr. David Calvert - Occupational Health Care Today Clinic__ Phone __865-268-1349__

Address __266 Joule Street_____ City __Alcoa_____ State __TN__ Zip __37701__

Is Telehealth available? Yes ☐ No ☒ If yes, web address _____

Physician Option 2 Name __Dr. Andrew Herda - Covenant Health Urgent Care__ Phone __865-982-3409__

Address __117 Gill Street_____ City __Alcoa_____ State __TN__ Zip __37701__

Is Telehealth available? Yes ☐ No ☒ If yes, web address _____

Physician Option 3 Name __Dr. Peter Gardner - Fast Pace Health__ Phone __865-273-9024__

Address __2166 East Broadway Avenue_____ City __Maryville_____ State __TN__ Zip __37804__

Is Telehealth available? Yes ☐ No ☒ 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 _____