

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 _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

Physician Option 1 Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

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

Physician Option 2 Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

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

Physician Option 3 Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

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 _____