Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, Tennessee 37243-1002

FORM C-42

EMPLOYEE'S CHOICE OF PHYSICIAN

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE:** Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

TO BE COMPLETED BY THE EMPLOYER:

Employer: 3104 _____ Date of injury: _____

Employer Contact: _____ Phone: _____ Email: _____

Horizon Medical Center
General Acute Care Hospital
111 Highway 70 E
Dickson, TN 37055
615-446-0446
Est Dist: 23.7 MI

Dickson Orthopaedics & Sports Medicine PLLC
Orthopaedic Surgery
196 Hillview St
Dickson, TN 37055
615-740-0080
Est Dist: 24.2 MI

Douglas, Allan S., DC
Douglas Chiropractic
Chiropractic
130 Hospital Dr
Camden, TN 38320
731-584-5444
Est Dist: 17.5 MI

Hillcrest Clinic PC
Family Practice
4891 E Main St
Erin, TN 37061
931-289-4201
Est Dist: 17.7 MI

Kleier Jr., Ernest B., MD
Surgery/General
209 W Main St
Waverly, TN 37185
931-296-9830
Est Dist: 0.1 MI

Oomman, Sowmini K., MD
Dickson Medical Associates, PC
Neurology
127 Crestview Park Dr
Dickson, TN 37055
615-446-5121
Est Dist: 20.3 MI

Salyer Jr., John R., MD
Dickson Medical Associates, PC
Family Practice
127 Crestview Park Dr Ste 104
Dickson, TN 37055
615-441-4478
Est Dist: 20.3 MI

Stephens III, Walter E., MD
Covenant Medical Group
Family Practice
200 Creekside Dr
Dickson, TN 37055
615-441-6140
Est Dist: 20.3 MI

TO BE COMPLETED BY THE EMPLOYEE:

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

Physician Name: _____ Date Selected: _____

Employee Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Employee Signature: _____ Date: _____

Oficina de Compensación a Trabajadores de Tennessee
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, Tennessee 37243-1002

FORMULARIO C-42
FORM C-42

SELECCIÓN DE MÉDICO POR UN EMPLEADO
EMPLOYEE'S CHOICE OF PHYSICIAN

Un empleador tiene que proporcionar un formulario parcialmente completado que enumere al menos tres médicos a un empleado al reportar una lesión que ocurrió en el lugar de trabajo. El empleado tiene que completar y luego firmar y fechar la sección abajo que indica el médico escojido. Una copia del formulario completado debe ser proporcionado al empleado y el original se debe mantener en los archivos del empleador. Si el empleado rehusa aceptar servicios médicos del médico escojido, los derechos a beneficios del empleado pueden ser retrasados. **NOTA:** Los empleados que viajan más de 15 millas de ida o de vuelta que tratamiento médico pueden pedir reembolso de sus gastos de viaje a la compañía aseguradora.

An employer must provide a partially-completed form listing at least three physicians to an employee upon the report of a workplace injury. The employee must complete and then sign and date the section below that indicates the physician chosen. A copy of the fully-completed form should be provided to the employee with the original kept on file by the employer. If the employee refuses to accept medical services from the chosen physician, the employee's rights to benefits may be delayed. **NOTE:** Employees traveling more than 15 miles one way to or from medical treatment may seek reimbursement of their travel expenses from the insurance carrier.

PARA SER COMPLETADO POR EL EMPLEADOR:
TO BE COMPLETED BY THE EMPLOYER:

Empleador (Employer): 3104 _____ Fecha de Lesión (Date of injury): _____

Contacto del Empleador (Employer Contact): _____ Teléfono (Phone): _____ Correo Electrónico (Email): _____

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Covenant Medical Group
Family Practice
200 Creekside Dr
Dickson, TN 37055
615-441-6140
Est Dist: 20.3 MI

PARA SER COMPLETADO POR EL EMPLEADOR
TO BE COMPLETED BY THE EMPLOYEE:

He seleccionado el siguiente médico de la lista que mi empleador me proprocionó:
I have selected the following physician from the list provided to me by my employer:

Nombre del Médico (Physician Name): _____ Fecha Seleccionada (Date Selected) _____

Nombre del Empleado (Employee Name): _____ Teléfono (Phone): _____

Dirección (Address): _____ Ciudad (City): _____ Estado (State): _____ (Código Postal) Zip: _____

Teléfono (Phone): _____ Correo Electrónico (Email): _____

Firma del Empleador (Employee Signature): _____ (Fecha) Date: _____