



**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: SONIC Corporation Date of injury: \_\_\_\_\_  
Employer Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Clarke, Stephen L., DC**  
*Chiropractors*  
6156 W Andrew Johnson Hwy  
Talbott, TN 37877  
423-581-7629

**Ballinger, Beth, MD**  
*Occupational Medicine Clinic*  
6350 W A J Hwy  
Talbott, TN 37877  
423-587-7337

**Harmeling, Mark P.**  
*Orthopedic Surgery*  
305 N Bellwood Rd  
Morristown, TN 37814  
423-586-5031

**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: \_\_\_\_\_

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