

IMPORTANT NOTICE:

Workers' Compensation

PANEL OF PHYSICIANS

The new workers' compensation legislation (Public Chapter 962), requires the Department of Labor and Workforce Development establish a form for employers to use to provide a panel of physicians (TCA 50-6-204(a)(4)(F)). The form requires the employee to document his/her selection of the attending physician by signature and date. A copy of the form (C-42(G)) approved by the Department to be used by governmental entities is attached. The form may be duplicated and used by any governmental entity. The employer must maintain a copy of the form and provide a copy to the employee. The employer is required to provide a copy to the Department of Labor and Workforce Development, Workers' Compensation Division upon request. This provision is effective for injuries on or after July 1, 2004.

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.

THIS FORM IS ONLY FOR USE BY GOVERNMENTAL ENTITIES ESTABLISHED BY TCA §29-20-401 AND SELF INSURED POOLS ESTABLISHED BY TCA §50-6-405(c)(1).

State File Number: _____ Date of Injury: _____
Employee: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ FEIN: _____
Address: _____ City: _____ State: _____ Zip: _____

PANEL OF PHYSICIANS

Tennessee Code Annotated §50-6-204(a)(4)(A) requires an employer to offer a panel of three physicians to the injured employee. The injured employee must select a physician from the panel.

Physicians Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Is Physician a Specialist? [] Yes [] No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Is Physician a Specialist? [] Yes [] No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Is Physician a Specialist? [] Yes [] No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Is Physician a Specialist? [] Yes [] No If yes, give specialty: Ortho, Neuro, etc. _____

Physicians Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Is Physician a Specialist? [] Yes [] No If yes, give specialty: Ortho, Neuro, 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.