



Tennessee Bureau of Workers' Compensation  
220 French Landing Drive, I-B  
Nashville, TN 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 \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer Contact \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

Physician Name \*Richard Rutherford of Carthage Family Practice Spec. Phone (615) 735-0700

Address 133 Hospital Dr, Ste 500 City Carthage State TN Zip 37030

Physician Name \*Kevin Rhody of Alexandria Family Medical Center Phone (615) 529-2116

Address 400 E Public Square City Alexandria State TN Zip 37012

Physician Name Fast Pace Urgent Care Carthage Phone (615) 486-6178

Address 573 Carthage Bypass City Carthage State TN Zip 37030

**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 \_\_\_\_\_

\* Preferred Provider

VERIFIED CARTHAGE 37030 LAT 6/14/17