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: Parking Company of America Date of injury: _____

Employer Contact: _____ Phone: _____ Email: _____

Concentra Medical Center
Occupational Medicine Clinic
Urgent Care Clinic
2831 Airways Blvd Bldg A Ste 102
Memphis, TN 38132
901-348-0200
Est Dist: 1.0 MI

Specialty Orthopedics
Surgery: Orthopedic
5220 Park Ave Ste 100
Memphis, TN 38119
901-682-9161
Est Dist: 6.9 MI

Nova Medical Centers
Occupational Medicine Clinic
Urgent Care Clinic
2781 Airways Blvd
Memphis, TN 38132
901-291-1100
Est Dist: 1.1 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
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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): Parking Company of America Fecha de Lesión (Date of injury): _____

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

Concentra Medical Center
Occupational Medicine Clinic
Urgent Care Clinic
2831 Airways Blvd Bldg A Ste 102
Memphis, TN 38132
901-348-0200
Est Dist: 1.0 MI

Specialty Orthopedics
Surgery: Orthopedic
5220 Park Ave Ste 100
Memphis, TN 38119
901-682-9161
Est Dist: 6.9 MI

Nova Medical Centers
Occupational Medicine Clinic
Urgent Care Clinic
2781 Airways Blvd
Memphis, TN 38132
901-291-1100
Est Dist: 1.1 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: _____

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Occupational Medicine Clinic
Urgent Care Clinic
2831 Airways Blvd Bldg A Ste 102
Memphis, TN 38132
901-348-0200
Est Dist: 0.4 MI

Specialty Orthopedics
Surgery: Orthopedic
5220 Park Ave Ste 100
Memphis, TN 38119
901-682-9161
Est Dist: 6.6 MI

Nova Medical Centers
Occupational Medicine Clinic
Urgent Care Clinic
2781 Airways Blvd
Memphis, TN 38132
901-291-1100
Est Dist: 0.5 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: _____

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Surgery: Orthopedic
5220 Park Ave Ste 100
Memphis, TN 38119
901-682-9161
Est Dist: 6.6 MI

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Urgent Care Clinic
2781 Airways Blvd
Memphis, TN 38132
901-291-1100
Est Dist: 0.5 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: _____