

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.