

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: Blount Memorial Occupational Health \_\_\_\_\_ Phone: (865)984-0100 \_\_\_\_\_

Address: 220 Associates Blvd \_\_\_\_\_ City: Alcoa \_\_\_\_\_ State: TN \_\_\_\_\_ Zip: 37701 \_\_\_\_\_

Is Physician a Specialist? [ ] Yes [x] No If yes, give specialty: Ortho, Neuro, etc. \_\_\_\_\_

Physicians Name: Dr. James D. Proffitt \_\_\_\_\_ Phone: (865)984-6823 \_\_\_\_\_

Address: 201 Corporate Place \_\_\_\_\_ City: Alcoa \_\_\_\_\_ State: TN \_\_\_\_\_ Zip: 37701 \_\_\_\_\_

Is Physician a Specialist? [ ] Yes [x] No If yes, give specialty: Ortho, Neuro, etc. \_\_\_\_\_

Physicians Name: Employee Health Care Center at East Tennessee Medical Group Care Today Clinic

Phone: (865)983-0093

Address: 266 Joule Street \_\_\_\_\_ City: Alcoa \_\_\_\_\_ State: TN \_\_\_\_\_ Zip: 37701 \_\_\_\_\_

Is Physician a Specialist? [ ] Yes [x] 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.