Attached is a panel of Physicians for this address

Aviation Consulting Experts, Inc
Bell Fight 157 Industrial Park Road
Piney Flat, TN 37686

Date created: 07/30/2021

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: Aviation Consulting Experts, Inc Date of injury: ______________

Employer Contact: ______________ Phone: ______________ Email: ______________

Dyer, Crystal S., MD
Family Practice
6070 Highway 11e
Piney Flats, TN 37699
423-538-5202
Est Dist: 0.0 mi

Grigsby, Holly C., MD
East Tennessee Recovery PLLC
Family Practice
2408 Susannah St Ste 4
Johnson City, TN 37601
423-434-6677
Est Dist: 6.3 mi

Brown, Andrew Y., MD
Piney Flats Urgent Care
Family Practice
6419 Bristol Hwy
Piney Flats, TN 37686
423-538-5202
Est Dist: 1.6 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: ______________ Appt Date/Time: ______________

Address: ______________ City: ______________ State: ______ Zip: ______________

Phone: ______________ Email: ______________

Employee Signature: ______________ Date: ______________

Oficina de Compensación a Trabajadores de Tennessee
Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 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): Aviation Consulting Experts, Inc ____ Fecha de Lesión (Date of injury): ____

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

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Est Dist: 1.6 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: ____