



Employer

- List at least three physicians and provide this panel to employee upon the report of a workplace injury.
- Keep the completed original form on file and send a copy to the employee for their records.
 - Do *not* send this form to the State unless requested.

Employee

- Fill out the bottom portion of this form to indicate which physician you choose.
 - If you refuse to accept medical services from the chosen physician, your rights to benefits may be delayed.
 - Traveling more than 15 miles (one way) to (or from) medical treatment? Employees may seek reimbursement of their travel expenses from the insurance carrier.
- **Send** completed form **back to your employer**.

TO BE COMPLETED BY THE **EMPLOYER**:

Employee Name _____ Date Panel Provided _____

Employer _____ Date of Injury _____

Employer Contact _____ Phone _____ Email _____

| Physician 1 | Physician 2 | Physician 3 |
|--|--|--|
| Name _____ | Name _____ | Name _____ |
| Phone _____ | Phone _____ | Phone _____ |
| Address _____ _____ | Address _____ _____ | Address _____ _____ |
| City _____ | City _____ | City _____ |
| State _____ Zip _____ | State _____ Zip _____ | State _____ Zip _____ |
| Is Telehealth available with Physician #1? Yes ___ No ___ | Is Telehealth available with Physician #2? Yes ___ No ___ | Is Telehealth available with Physician #3? Yes ___ No ___ |
| If yes, web address _____ | If yes, web address _____ | If yes, web address _____ |
| (Optional) Telehealth-Only Physician 4 Name _____ Phone _____ | | |
| Telehealth Provider email address _____ Web address _____ | | |

TO BE COMPLETED BY THE **EMPLOYEE**:

I have selected the following physician from the list provided to me by my employer:

Physician Name _____ Appt Date/Time _____

I select: In-person treatment ___ **or** Treatment by Telehealth ___ Were you offered in-person treatment? Yes ___ No ___

Employee Signature _____ Date _____