



**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 <b>Physician 4</b> 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 \_\_\_\_\_