



**Choice of Medical Provider Form**

(to be completed by Supervisor/OSHA Coordinator and signed by employee prior to visit)

**INITIAL TREATMENT/MINOR-EMERGENCY: (Please select one facility)**

**OCCUPATIONAL MEDICINE:**

Concentra Medical Center (8a-6p M-F)  
2831 Airways Building A, Suite 102  
Memphis, TN 38132  
(901)348-0200 Fax: (901) 348-0046

**Occumed Clinic** (8a-5p M-F)  
1785 Nonconnah Blvd #120  
Memphis, TN 38132  
(901) 345-6700 Fax (901) 345-6755

Concentra Medical Center (8a-6p M-F)  
3965 S. Mendenhall Rd, Suite 6 Bldg. G  
Memphis, TN 38115  
(901)365-1800 Fax: (901)365-1862

**MINOR MED CLINICS:**

**Methodist: Injuries Only/No Exposures)**

Methodist Minor Medical (8a-7p M-F & 8a-6p SS)  
8071 Winchester & 8095 Club Parkway  
Memphis, TN 38125 Cordova, TN 38016  
(901)756-6056 Fax: 624-0702 (901)758-6035 Fax:758-6029

Methodist Minor Medical (2p-10p M-F & 12p-9p SS)  
1803 Union Avenue  
Memphis, TN 38104  
(901)722-3152 Fax: (901) 722-3129

**Baptist: (Injuries Only/No Exposures)**

Baptist Minor Medical Center (8a-7:30p everyday)  
3295 Poplar Avenue, Suite #105  
Memphis, TN 38111  
(901)327-8188 Fax: (901) 327-8284

Baptist Minor Medical Center (8a-7:30p everyday)  
670 N. Germantown Parkway, Suite 18 (Trinity Commons)  
Cordova, TN 38018  
(901)753-7686 Fax: (901) 759-9968

**Facility Selected/Address:** \_\_\_\_\_ **Employee Name:** \_\_\_\_\_

**Type of Injury:** \_\_\_\_\_ **DOI:** \_\_\_\_\_ **Time of Injury:** \_\_\_\_\_

**Division:** \_\_\_\_\_ **Department:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_

**Supervisor/OSHA Name/Signature:** \_\_\_\_\_

I \_\_\_\_\_, understand and agree that in the event benefits are paid for charges incurred by an employee as a result of accidental bodily injury or disease sustained by such employee, the employee shall reimburse the City OJI Office to the extent of such benefit payments (1) out of any recovery (whether by settlement, judgement, or otherwise) made against any person or organization responsible for causing such injury or disease, and the City OJI Office shall have a lien upon any recovery received from such injury or disease; (2) but in no event shall such employee be required to make reimbursement in an amount exceeding the recovery received by him/her against the person or organization responsible for causing the injury or disease. I must notify the City's Health and Safety Office, Third Party Administrator or the City Attorney's Office that a claim or lawsuit has been filed against the third party and/or the third party's insurance company within thirty days of the filing of said action. I agree by signature of this agreement that failure to notify the City of legal representation and/or acceptance of any settlement amount could result in the City's reimbursement being deducted from any wages/salaries.

**Employee signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\*A copy of this form must be given to the employee to take to the medical facility and sent to TPA via fax at (901)566-3415 \*\*\***

**\*\*\* If specialty care is needed, employee must IMMEDIATELY contact TPA for instructions and authorization\*\*\*\***

**\*\*\*Authorization and/or payment for an initial visit with a health care provider does not deem an on the job injury compensable until a final determination is made by the TPA. In the event the OJI is not deemed compensable, the employee will be personally responsible for any and all treatment \*\*\***