

FORM C-42

TENNESSEE  
BUREAU OF WORKERS' COMPENSATION



EMPLOYEE'S  
CHOICE OF PHYSICIAN  
Medical Panel

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 (oneway) 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 Vanderbilt University \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer Contact Tracy Woodard Phone 615-343-3788 Email Tracy.Woodard@Vanderbilt.edu

Employer Contact Patricia Parker Phone: 615-343-1166 Email: Patricia.Parker@Vanderbilt.edu

Physician 1	Physician 2	Physician 3
Name <u>Dr. Robert Thompson</u>	Name <u>Dr. Yu / Dr. Corn</u>	Name <u>Dr. Michel Taylor</u>
Phone <u>615-329-6600</u>	Phone <u>615-329-6600</u>	Phone <u>615-342-6300</u>
Address <u>1800 Medical Center Parkway</u>	Address <u>8 City Boulevard, Suite 300</u>	Address <u>2400 Patterson Street, Suite 300</u>
City <u>Murfreesboro</u>	City <u>Nashville</u>	City <u>Nashville</u>
State <u>TN</u> Zip <u>37129</u>	State <u>TN</u> Zip <u>37203</u>	State <u>TN</u> Zip <u>37203</u>
Is Telehealth available with Physician #1? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, webaddress _____	Is Telehealth available with Physician #2? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, web address _____	Is Telehealth available with Physician #3? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 \_\_\_\_\_