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 (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 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 Dr. Blake Garside / Dr. Timothy Steinagle	Name Dr. Robert Clendenin	Name Dr. Joseph Schaffer
Phone 615-329-6600	Phone 615-329-6600	Phone 615-332-3614
Address 300 Stonecrest Boulevard, Suite 300	Address 8 City Boulevard, Suite 100	Address 394 Harding Place
City Smyrna	City Nashville	City Nashville
State TN Zip 37167	State TN Zip 37203	State TN Zip 37211
Is Telehealth available with Physician #1? Yes ☐ No ☐ If yes, web address ____ ____	Is Telehealth available with Physician #**2**? Yes ☐ No ☐ If yes, web address ____ ____	Is Telehealth available with Physician #**3**? Yes ☐ No ☐ 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** ~~Tre~~atment by Telehealth ☐ Were you ~~offe~~red in-person treatment? Yes ☐ No ☐ Employee Sign~~ature~~ Date ____