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 Craig Morrison	Name Phillip Karpos / Chris Anderson	Name Dr. Lucas Burton
Phone 615-342-3038	Phone 615-383-2693	Phone 615-329-6600
Address 2400 Patterson Street, Suite 100	Address 4230 Harding Place, Suite 1000	Address 8 City Boulevard
City Nashville	City Nashville	City Nashville
State TN Zip 37203	State TN Zip 37205	State TN Zip 37209
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 ___