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. Richard Rubinowicz	Name Dr. Subir Prasad	Name Dr. W. Garrison Strickland
Phone 615-355-5510	Phone 629-255-2128	Phone 615-284-2214
Address 310 25th Avenue North	Address 4230 Harding Place, Suite 805	Address 300 20th Avenue North, Suite 600
City Nashville	City Nashville	City Nashville
State TN Zip 37203	State TN Zip 37205	State TN Zip 37203
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 ___