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, signed version of this 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 Medical Center Date of Injury _____

Employer Contact Teresa Overton, Director of Claims Phone 615-936-9290 Email teresa.overton@vumc.org

Physician 1	**Physician 2**	**Physician 3**
Name James Felch, MD VEI	Name Dr. Melissa Toyos	Name Terrence Doherty MD
Phone 615-936-0955	Phone 615-327-4015	Phone 615-383-7778
Address 2311 Pierce Ave	Address 2204 Crestmoor Road	Address 21st Avenue S
_____	_____	_____
City Nashville	City Nashville	City Nashville
State TN Zip 37232	State TN Zip 37215	State TN Zip 37212
Is Telehealth available with Physician #1? Yes ☐ No ☐	Is Telehealth available with Physician #2? Yes ☐ No ☐	Is Telehealth available with Physician #3? Yes ☐ No ☐
If yes, web address	If yes, web address	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** Treatment by Telehealth ☐ Were you offered in-person treatment? Yes ☐ No ☐

Employee Signature _____ Date _____