Transit Case No._____ TWU Case No._____

Medical Appeal (Injury on Duty Cases)

Employee Name_____ Pass_____ Title_____ Dept/Div_____

I hereby dispute the work status determined by the Independent Medical Examiner (IME). I assert that I no longer suffer from a work-related disability and should be considered Full Work in my current title. I request that this dispute be submitted to an Impartial Physician for review and determination. I hereby authorize the release of my WCD medical record to TWU Local 100.

Work Status as of date of Medical Appeal_____ (indicate Restricted Work (RW) or No Work (NW)).

Date when disputed IME work status first determined by IME (if known):_____

_____ _____

Employee Signature Dated Street Address

( )_____ _____

Telephone Number City, State, Zip Code

To be completed by the Employee's Physician: (Statement of Dispute and Medical Findings) (Please attach any relevant objective medical findings, including diagnostic test results, medical history, etc. in order to assist the Impartial Physician in making a determination.)

_____

_____

_____

_____

_____

_____ ( )_____

Physician's Signature Dated Physician's Telephone Number

Physician's Stamp

Waiver: (optional): If the WCD determines that I have supplied sufficient medical evidence to warrant an expedited IME prior to an Impartial Physician visit, I hereby waive my statutory right to seven (7) days' notice of such scheduled IME visit. _____

Employee Signature

Date Appeal Received by the Workers Compensation Division (WCD)_____ WCD Representative_____

Fax completed forms with documentation to (718) 694-1025 or mail or hand deliver to Workers Compensation Division, 130 Livingston St., 10th Floor, Brooklyn, NY 11201 AND email the same to calendars@twulocal100.org or mail to TWU Local 100 Grievance Department, 3rd Floor, 195 Montague Street, Brooklyn, NY 11201 or Fax (347)916-0563