Transit Case No._____ TWU Case No._____

Medical Appeal to Tripartite Panel – Non IOD Cases

Employee Name_____ Pass_____ Title_____ Dept/Div_____

I hereby dispute ☐ the medical condition and/or ☐ the work status that OHS has determined. I hereby request that this dispute be submitted to a Tripartite Physician Panel for review and determination. I hereby authorize the release of my OHS medical record to TWU Local 100.

Occupational Health Services (OHS) Work Status as of date of Medical Appeal_____ (indicate Full Work (FW), Restricted Work (RW) or No Work (NW)).

Date when disputed OHS work status first determined by OHS (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 Condition) (Please attach any relevant medical evidence, including diagnostic test results, medical history, etc. in order to assist the Tripartite Panel in making its determination.)

_____

_____

_____

_____

_____

_____

_____ ( )_____

Physician's Signature Dated Physician's Telephone Number

Physician's Stamp

Date Appeal Received by the Occupational Health Services (OHS)_____ OHS 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