

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 Occupational Health Services (OHS): _____

OHS Representative _____

Union or Employee must fax completed forms with documentation to (347) 643-8187 or mail or hand deliver to Occupational Health Services, 180 Livingston Street, Rm. 4023A, Brooklyn, NY 11201. Employee must also fax the forms with documentation to (212) 724-6336 or mail or hand deliver to TWU Local 100, Grievance Dep' t., 10019 Avenue, New York, NY 10019.
 → new fax no: 646 998 7157
 1700 Broadway