

VERIZON LABOR RELATIONS
3RD MEDICAL OPINION REQUEST (TMO)

Union Local: _____ Date: _____

Requested By: _____ Title: _____

Local's Fax No. _____

Employee Name: _____ S.S. #: _____

Title: _____ N.C.S.D: _____

Director: _____ Telephone: _____

Reporting Location: _____

EE's Work Phone No: _____

EE's Home Address: _____

EE's Home Telephone No: _____

(Check appropriate box)

Workers Comp Occ. Health MetLife

Reason for Request: _____

Date (s) in Dispute: _____

Last Date Justified: _____

Employee's Personal Primary Physician:

Name: _____ Telephone _____

Address: _____
