

**IOD/SLH/PT/CROSS-UTILIZATION
PANEL SUMMARY SHEET**

NAME OF GRIEVANT: _____ STATION: _____ LOCAL: _____

PANEL: _____ DATE SUBMITTED TO INT'L _____

DOCUMENTS SUPPORTING GRIEVANT'S CASE: "CHECK APPROPRIATE BLOCK"

DOCTORS STATEMENT: [] WITNESS STATEMENT: [] IOD REPORT: []

C 21: [] C 23: [] MEDICAL DIAGNOSIS & PROGNOSIS: _____

LENGTH OF DISABILITY LEAVE: YRS: _____ MONTHS: _____
(IF APPLICABLE)

IF IOD CLAIM: WORKDAYS LOST _____

DESCRIBE GRIEVANCE: _____

REPORT SUBMITTED BY: _____

UNION POSITION: _____ DATE: _____

FOR OFFICE USE ONLY

CASE NUMBER: _____ DATE SUBMITTED TO AMERICAN: _____

OTHER: _____
