Procedure for Filing Grievances for Matters Related to Occupational Health

1. Employees with concerns about a decision made by Occupational Health should first attempt to resolve the matter with a Nurse Case Manager by calling the Occupational Health VRU (800-409-7425).

2. If, after speaking with a Nurse Case Manager, the employee wants the decision reviewed, the employee should call the Medical Helpline (800-454-1960). The employee will be asked to complete an Authorization for Release of Health Information to allow the Medical Helpline representative to discuss the employee's medical information with Occupational Health.

3. If, after taking the above steps, the employee believes the company violated the contract, the union may file a grievance up to 30 calendar days from the date the Medical Helpline representative informs the employee of its final determination, following this modified grievance procedure:

   Step One: The employee's Business Agent or designee (including an acting Business Agent but not the employee or shop steward) will present the grievance to the Manager in HR - Labor & Wage*. The employee must sign an Occupational Health Grievance Authorization to allow the company and the union to discuss the employee's medical information for grievance purposes. This authorization is separate and apart from the authorization completed for the Medical Helpline.

   Step Two: If the employee is dissatisfied with the decision of Step One, the Business Agent or designee may submit the grievance to the Director of Occupational Health or designee.

   Step Three: If the employee is dissatisfied with the decision of Step Two, the Senior Business Agent or designee may present the grievance to the Vice President of Human Resources or designee.

4. If remedy is still sought after the above steps, the Union may file a demand for arbitration.

* The current Manager of HR – Labor & Wage:
Christiane Gabriel (212) 780-8236
gabrielch@coned.com

ANSWER THE QUESTIONS BELOW FOR MEDICAL GRIEVANCES ONLY AFTER YOU HAVE REACHED OUT TO THE MEDICAL HELPLINE 800-454-1960

- **WHAT** IS THE MEDICAL ISSUE/CONDITION:

- **WHEN** DID YOUR MEDICAL ISSUE FIRST OCCUR AND ON WHAT DATES WERE YOU AT MEDICAL:

- **WHY** DID THIS MEDICAL ISSUE ARISE (WORKER COMP/OUT SICK/DOT VISIT):

CONSOLIDATED EDISON COMPANY OF NEW YORK, INC.
OCCUPATIONAL HEALTH GRIEVANCE AUTHORIZATION

I, _____ [Employee Name], _____ [Employee Number], request that the Consolidated Edison Occupational Health Department ("Occupational Health") release health information regarding my care and treatment as set forth in this authorization. I authorize Consolidated Edison's Human Resources Department ("HR") and UWUA Local 1-2's Business Agent or designee ("Local 1-2") to use, disclose, and discuss my health information as may be required in order to review my grievance. Specifically, I authorize the release of my records regarding my absence from _____ (date) to _____(date). I authorize HR and Local 1-2 to receive and use the identified protected health information from Occupational Health and my private health care providers in an effort to resolve my grievance.

I understand that this authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV-related information only if I place my initials here _____. In the event the health information described above includes any of these types of information, and I placed my initials where instructed, I specifically authorize release of such information to HR and Local 1-2.

If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, HR and Local 1-2 are prohibited from re-disclosing such information without my authorization, except as necessary to attempt resolution of my grievance, unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.

I understand that I have the right to revoke this authorization at any time by notifying HR in writing at 4 Irving Place, 15th Floor, New York, NY 10003 or by fax at (718) 246-7554. I understand that the revocation is only effective after it is received and logged by HR.

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that after this information is disclosed, it may be re-disclosed, and the law might not protect it. I understand that I am entitled to receive a copy of this authorization. I understand that this authorization will expire at the earlier of six months or the resolution of my grievance.

Signature of Employee: _____ Date: _____

Return to: Christiane Gabriel
HR Labor & Wage
4 Irving Pl, M020
15th Floor
New York, NY 10003
Fax # 718-246-7554

Utility Workers Union of America, Local 1-2
5 West 37th Street, New York, NY 10018 – 7th Floor
Phone: (212) 575-4400 Fax: (212) 575-3852

AUTHORIZATION FOR RELEASE OF MEDICAL & SURGICAL RECORDS

I, _____, authorize _____
Member Name Doctors Name

to release the records described below to the persons or organizations described below for the purposes described below:

The information that may be released is the following:

_____

_____

Person or organization to whom the records to be released:

_____

Name

_____

Address City State Zip

The information may be used for the following purposes:

_____

The authorization is valid from the date signed until the following date or event: _____. However, I may revoke this consent at anytime, except to the extent that action has been taken in reliance on it.

_____ I explicitly consent to the release of **Alcohol and Drug Abuse patient Records.**
Initials

I understand that Alcohol and Drug Abuse Patient Records are protected by federal regulations 42 CFR Part 2.

_____ _____
Member Name Date

Please return completed form to:
UWUA, Local 1-2
5 West 37th Street, 7th Floor New York, NY 10018
or via fax to: (212) 575-3852

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Professional Medical Conduct

Complaint Form

Please print and complete all sections of this form and mail to:
Office of Professional Medical Conduct
Central Intake Unit
Riverview Center
150 Broadway, Suite 355
Albany, New York 12204-2719

(This form must be mailed and include an original signature)

All reports of misconduct are kept confidential and are protected from disclosure according to New York State Public Health Law, Sections 230(10)(a)(v) and 230(11)(a). Any person who reports or provides information to the Board for Professional Medical Conduct in good faith, and without malice, shall not be subject to an action for civil damages or other relief as the result of making the report according to Section 230(11)(b).

SEE ATTACHED INSTRUCTIONS BEFORE COMPLETING

INFORMATION ABOUT YOU

Name _____ _____ _____
(Last) (First) (MI)

Address _____ _____ _____ _____
(No. and Street) (City) (State) (Zip Code)

Telephone (____) _____ (____) _____
Day Evening
(PLEASE PROVIDE A NUMBER WHERE YOU CAN BE REACHED)

PHYSICIAN OR PHYSICIAN ASSISTANT

Name _____ _____ _____
(Last) (First) (MI)

Address _____ _____ _____ _____
(No. and Street) (City) (State) (Zip Code)

Telephone (____) _____

COMPLAINT

DESCRIBE YOUR COMPLAINT AS COMPLETELY AS YOU CAN. PLEASE SIGN AND DATE THE FORM.

Patient's Name _____ _____ _____
(Last) (First) (MI)

Date of Birth ____ ____ ____ ____ ____ ____ ____ ____
Month Day Year

When did this happen? _____

Where did this happen? _____

Have you filed a complaint with anyone else? ☐ Yes ☐ No

If yes, with whom? _____

Complaint Form

Names of Witness (es) _____ _____ _____
(Last Name) (First Name) (MI)

_____ _____ _____
(Last Name) (First Name) (MI)

Explain _____

Utility Workers Union of America, AFL-CIO

Local 1-2

5 West 37th Street New York, NY 10018
(212) 575-4400

GRIEVANCE REPORT

Member's Name _____ Employee No. _____

Home Address _____ Home Phone No. _____

_____ Title _____

Company _____ Department _____ Bureau _____

Work Location _____ Supervisor _____

Nature of Grievance—PLEASE CHECK THE APPROPRIATE BOX BELOW

- ☐ Termination
- ☐ Suspension
- ☐ Denied Progression
- ☐ Denied Merit
- ☐ Other (Warnings) Give a brief explanation below

_____

_____

Clause of Contract Violated (list articles violated)

_____

Remedy ☐ To be made whole, including but not limited to any lost wages, benefits, merit increases and progressions.

☐ Other (Give a brief explanation below)

_____

_____

Today's Date _____ Signature of Member _____

Result of 1st Step in Grievance Procedure

Date of Grievance Meeting _____

Names of Stewards _____

Name of Company Representative _____

Names of Others Present _____

_____

Was information requested in writing by Steward? ☐ Yes ☐ No

Was information provided by Company Rep? ☐ Yes ☐ No

Did Company Rep provide written response? ☐ Yes ☐ No

Signature of Steward _____

Result of 2nd Step in Grievance Procedure

Date of Grievance Meeting _____

Name of Agent / Designee _____

Name of Company Representative _____

Names of Others Present _____

_____

Was information requested in writing by Agent / Designee? ☐ Yes ☐ No

Was information provided by Company Rep? ☐ Yes ☐ No

Did Company Rep provide written response? ☐ Yes ☐ No

Settlement: Yes _____ No _____

Signature of Business Agent / Designee _____

Result of 3rd Step in Grievance Procedure

Date of Grievance Meeting _____

Name of SBA / Designee _____

Name of Company Representative _____

Names of Others Present _____

_____

Was information requested in writing by SBA / Designee? ☐ Yes ☐ No

Was information provided by Company Rep? ☐ Yes ☐ No

Did Company Rep provide written response? ☐ Yes ☐ No

Settlement? Yes _____ No _____

Signature of Senior Business Agent / Designee _____

************Guidelines for Grievance Process************

- This form stays in the possession of the Union at all times
- All information on this form is to be filled out by the union representative
- Make a copy of Grievance Report, Information Requests and all notes for your records

  For example: Disciplinary Interview Report
  Statements from witnesses
  Statement from Grievant
  Steward's notes from interviews
  Employee Evaluations
  All other relevant documents

- Place originals in envelope and give to next Union Representative in preparation for next step of grievance process

conEdison
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003
(P) 212 780 7069 (F) 212 780 7995

Date: _____

RELEASE OF MEDICAL INFORMATION TO CON EDISON OCCUPATIONAL HEALTH DEPARTMENT

TO WHOM IT MAY CONCERN:

I, _____, Employee Number _____

hereby authorize _____

Address: _____

To release to the Consolidated Edison Co. Inc., Occupational Health Department, 11th floor,

4 Irving Place, New York, N.Y. 10003, all Medical information regarding the following:

_____

_____

_____

_____

_____ _____

Witnessed Employee Signature

_____ _____

Health Care Professional Signature Date