



GRIEVANCE FORM

(Please Type or Print)

Revised: March 1, 2003

LOCAL Grievance Number: _____

Facility (or Agency): _____

Aggrieved Employee: _____

LOCAL Union Rep: _____

Phone Number/ext. _____

DO NOT WRITE IN THIS BOX

NYSCOPBA Grievance Number: **CON** _____

Date Submitted: _____

Date of Occurrence: _____

Contract Article Violation(s): _____

STATEMENT OF FACTS: _____

REMEDY SOUGHT: _____

Aggrieved Employee's Signature: _____

STEP I DECISION

Date Received: _____

Date of Review: _____

Superintendent or Designee: _____

Date Answered: _____

Received by (Union Official): _____

Date Received: _____

APPEAL TO STEP II

FACTS OF APPEAL:

Signature: _____

Date Appealed: _____