

**NEW YORK STATE / NYSCOPBA**  
**OUT-OF-TITLE WORK GRIEVANCE FORM**

Date Submitted \_\_\_\_\_

Grievant(s) Name

Social Security Number

Home Address

Grievant(s) Title

Line Number

Department/Facility

Division/Bureau/Region

Shift

Work Address

Supervisor's Name and Title

**STATEMENT OF FACTS**  
**(USE ADDITIONAL SHEETS IF NECESSARY FOR QUESTIONS 1-4)**

**1. Reason for Grievance:**

- a. Who directed you to perform these tasks, their name and title? \_\_\_\_\_
- b. What caused this assignment, did someone get sick, go on leave, get reassigned? \_\_\_\_\_  
\_\_\_\_\_
- c. Were you filling in for your supervisor, if so how often? \_\_\_\_\_
- d. Were you performing all of the duties of your supervisor at that time? \_\_\_\_\_
- e. Who supervised you when you performed these tasks (who did you report to)? \_\_\_\_\_
- f. What title did you feel should normally be assigned these duties? \_\_\_\_\_
- g. What were the dates of the assignment, number of days or weeks? \_\_\_\_\_

2. Specific tasks performed which you believe to be out-of-title and approximate percentage of time spent on each: \_\_\_\_\_  
\_\_\_\_\_

**NOTE: If the duties are appropriate to your present job title, an out-of-title work grievance is not applicable, and this grievance form should not be used**

3. State the title and grade that you believe are more appropriately assigned these duties: \_\_\_\_\_

4. If relevant, list your supervisory responsibilities, along with names and titles of staff supervised by you: \_\_\_\_\_  
\_\_\_\_\_

5. Date(s) of occurrence: \_\_\_\_\_

6. Remedy sought:      ☐ Compensation/Monetary Relief      ☐ Cease and Desist

7. Signature of Aggrieved Employee or Union Officer and Title: \_\_\_\_\_

**STEP 1 – FACILITY/REGIONAL LEVEL REVIEW**

|   |                      |
|---|----------------------|
| Date Grievance Received by Certified Mail | Date Decision Issued |
| Union File Number                         | Agency File Number   |

1. Facility/Regional Level Management Decision: \_\_\_\_\_  
\_\_\_\_\_
2. Facility/Regional Reviewer: \_\_\_\_\_

**STEP 2 – AGENCY LEVEL REVIEW**

|   |                      |
|---|----------------------|
| Date Grievance Received by Certified Mail | Date Decision Issued |
|---|----------------------|

Agency Decision \_\_\_\_\_  
\_\_\_\_\_

Agency Reviewer \_\_\_\_\_

**GOVERNOR’S OFFICE OF EMPLOYEE RELATIONS (GOER) REVIEW (STEP 3)**

GOER File Number \_\_\_\_\_

All appeals to GOER must include a legible copy of the grievance form and agency opinion, and specific reasons for disagreement with step 2 decision

Date Grievance Sent by Certified Mail: \_\_\_\_\_

Signature of Aggrieved Employee or Union Officer: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NEW YORK STATE  
OUT-OF-TITLE WORK GRIEVANCE FORM  
INSTRUCTIONS**

It is especially important for you to supply as much information as possible so that your grievance will not be delayed by a request for additional information.

You should contact your local grievance representative to assist you in filling out this form and to assist you in determining whether the particular circumstances you are grieving are appropriate to the out-of-title work grievance procedure.

You should state the specific tasks that you performed which you believe to be out of title. These are tasks not contained in the job standard or tasks not normally associated with your title.

Any attachments must be included with the grievance form at each step.