

Date: \_\_\_\_\_

Grievance No.: \_\_\_\_\_

Employee Last Name:	First Name:	Job Title:
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UMID:	Department:	Department Head's Name:
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**Work Schedule information MUST be completed**

Work Schedule: from: \_\_\_\_\_  am  pm to: \_\_\_\_\_  am  pm

Check appropriate days:  M  TU  W  TH  F  SAT  SUN

Employee's Statement of Grievance (include facts, dates, provisions of the agreement violated and remedy desired).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employee's SIGNATURE:	DATE Received by Department Head:
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Chief Steward's NAME: \_\_\_\_\_

Department Head's Decision

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Department Head's SIGNATURE:	DATE given to Employee:
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