Send to: Grievance@alamedahealthsystem.org

LOCAL 1021

ALAMEDA HEALTH SYSTEM
STANDARD GRIEVANCE FORM

NAME OF GRIEVANT: ______________________________ STEWARD/MEMBER/REP: ______________________

POSITION/CLASSIFICATION: ____

CONTACT INFO (EMAIL/PHONE) ____________________ / ______________________________

DEPARTMENT/WORK LOCATION/CAMPUS: __________________ / ______________________ / __________________

IMMEDIATE SUPERVISOR/MANAGER: ______________________ / ___________________________

EVENT DATE CAUSING GRIEVANCE: _______________________ DATE OF GRIEVANCE: ________________________

NATURE OF GRIEVANCE: (STATE GRIEVANCE AND FACTS UPON WHICH IT IS BASED) ______________________________

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SECTION OF CONTRACT/POLICY CLAIMED TO BE VIOLATED: ____

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REMEDY OR CORRECTION DESIRED FROM EMPLOYER: ____

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____

IMPACTED WORKER(S): ____

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DATE OF INFORMAL MEETING (STEP 1): _________________________

AHS AND UNION ATTENDANTS OF INFORMAL MEETING (STEP 1): _________________________ / _____________________

BY FILING THIS GRIEVANCE, THE UNION DOES NOT INTEND TO WAIVE, NOR DOES IT WAIVE, ANY ADDITIONAL PROCEDURAL OR SUBSTANTIVE RIGHTS OR CAUSES OF ACTION WHICH AN EMPLOYEE MAY HAVE PURSUANT TO ANY FEDERAL LAW, STATE LAW OR OTHER RULE OR REGULATION.