RI Hospital UNAP Grievance FACT Sheet

THIS INFORMATION IS FOR THE UNION'S USE ONLY

Fax this form to the Union office AND give a copy to your Unit Rep immediately after the date of th occurrence in order to allow sufficient time for the grievance to be processec

PLEASE CALL THE UNION OFFICE IF THIS FACT SHEET/GRIEVANCE HAS NOT BEEN COMPLETED OR REPORTED TO THE UNION WITHIN 10 DAYS OF THE OCCURRENCE.

GRIEVANT NAME: _____ UNIT: _____ SHIFT: _____ DOH: _____

Work phone: _____ Home Phone: _____ Cell phone: _____ Email: _____

What phone number is best to reach you? _____

UNIT REP NAME: _____

Check the box(es) that apply.

☐ I gave my Unit Rep a copy of this document on _____ (date).

☐ I discussed the issue with my Unit Rep .

☐ There is no Unit Rep for our unit/department.

SUPERVISOR NAME: _____ phone: _____

Who was involved? Give name(s) and titles. Include witnesses. _____

_____

What happened? Describe incidents which gave rise to the grievance. _____

_____

_____

_____

_____

_____

Where did it occur? Specific locations _____

When did it occur? Date(s) and time(s _____

Why is this a grievance? What is the violation? (Contract language, hospital policy, unfair treatment, past practice, local, state or federal laws). _____

_____

_____

What is the remedy? (What must management do to correct the problem?) _____

_____

_____

FAX 401/831-3677. Call within 24 hours to confirm fax was received at 401/831-3647 ext 11