COUNTY OF SANTA CRUZ
EMPLOYEE GRIEVANCE FORM
PHYSICIANS' REPRESENTATION UNIT

GRIEVANCE NO._____
(Management Representative
obtains from Personnel Dept)

TO BE COMPLETED BY EMPLOYEE - Use ink or typewriter
Name_____ Class Title_____
Department_____ Division or Unit_____
Grievance occurred: Date_____ Time_____ Location_____
When did you first learn of the issue on which you are filing the grievance_____
Informal attempt to resolve:
Grievance discussed with _____
(Name and title of employee's supervisor)
On (date)_____ at (time)_____.
What else have you done to resolve this grievance_____
_____
_____
_____
_____
_____
Statement of grievance, clearly indicating what the problem is and how your wages, hours
or conditions of employment have been adversely affected:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
Indicate Article or Section number and title which has been violated:
Memorandum of Understanding _____
Section 160 (Salary, Compensation & Leave Provisions)_____

Suggested corrective action_____
_____
_____
_____
_____
_____
_____
State who (if anyone) will represent you in this matter_____

Submitted to Step 1: _____ _____ Date submitted Signature of Grievant _____ _____ Date received Signature of Mgt Rep Submitted to Step 2: _____ _____ Date submitted Signature of Grievant _____ _____ Date received Signature of Mgt Rep	Submitted to Step 3: _____ _____ Date submitted Signature of Grievant _____ _____ Date received Signature of Mgt Rep FOR TIMELINES AND PROCEDURES, SEE MOU ARTICLE 20. Any mutual waiver of time limits should in writing & a copy attached to this form.

PER 1307 4/04, Rev. for Intranet Use 5/22/14
DISTRIBUTION: Original to Management representative designated to hear grievances.
1 Copy - to Employee 1 Copy - to Personnel Department
1 Copy – to Union of American Physicians & Dentists