

Please Type or Print Using Black ink. See Reverse Side for Instructions on completing form.

NEW YORK STATE/PBANYS OUT-OF-TITLE WORK GRIEVANCE FORM

Date Submitted: _____

| | | |
|------------------------------------|------------------------|----------|
| Grievant(s) Name | | |
| Home Address | | |
| Grievant(s) Title and Salary Grade | | Line No. |
| 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. The date(s) of assignment, number of times, number of days, number of weeks. _____

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

NOTE: **If 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 the names and titles of staff supervised by you:

5. Specific Date(s) of Occurrence: _____
6. Remedy Sought: Compensation/Monetary Relief Cease and Desist
7. Signature of Aggrieved Employer or Union Officer & Title: _____

STEP 1 – FACILITY/REGIONAL LEVEL REVIEW

| | |
|---|----------------------|
| Date Grievance Received by Certified Mail | Date Decision Issued |
| Union File No. | Agency File No. |

1. Facility/Regional Level Management Decision: _____

2. Facility/Regional Reviewer (Name): _____

STEP 2 – AGENCY LEVEL REVIEW

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

Agency Decision: _____

Agency Reviewer: _____

OFFICE OF EMPLOYEE RELATIONS (OER) REVIEW (Step 3)

OER File No. _____

All appeals to OER 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.