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

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

Bargaining Unit:
☐ Security Services Unit

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 I – 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: _____

_____

GOVERNOR'S OFFICE OF EMPLOYEE RELATIONS (GOER) REVIEW (Step 3)

GOER File No. _____

All appeals to GOER 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.