

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:
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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.