



STAFF EMPLOYEE GRIEVANCE FORM

Note to Grieving Party: This document must be submitted to the Vice President of Human Resources or his/her designee **no later than 14 calendar days from the effective date of the adverse employment action**. Please ensure all information below is completed in full prior to submission of this form.

GRIEVING PARTY'S NAME: _____

GRIEVING PARTY'S EMPLOYEE ID#: _____

GRIEVING PARTY'S TITLE: _____

GRIEVING PARTY'S DEPARTMENT: _____

GRIEVING PARTY'S DIVISION: _____

GRIEVING PARTY'S SUPERVISOR: _____

GRIEVING PARTY'S CONTACT INFORMATION

MAILING ADDRESS: _____

HOME PHONE NUMBER: _____

CELL PHONE NUMBER: _____

E-MAIL ADDRESS: _____

TIME IS OF THE ESSENCE IN PROCESSING GRIEVANCE PETITIONS. IDENTIFY THE MOST EXPEDIENT WAY TO CONTACT THE GRIEVING PARTY DURING THE COURSE OF THE GRIEVANCE PROCESS:

I. Identify in detail the basis for your grievance including the specific **adverse employment action** you are grieving. (If you need additional space provide as attachment. Also, if you have additional documents that you believe support your grievance petition, please attach)

II. What is the effective date of the adverse employment action: _____

III. Identify the relief you are requesting from the College of Charleston:

IV. What is the total number of pages you are submitting as part of this Grievance Form: _____

Signature of Employee:

I certify that the information contained in this Grievance Petition is true and accurate to the best of my knowledge.

Employee Signature

Date