

ASSOCIATION OF DIAGNOSTIC IMAGING TECHNOLOGISTS
ADIT
GRIEVANCE FORM

Name of Member _____ Date _____
Please Print

Home Address _____
Street City Zip Code

Phone (W) _____ (H) _____ Hospital _____

Name of Supervisor _____ Phone _____

Have you discussed your Grievance with your Supervisor? Yes _____ No _____
If "Yes" on what date? _____

Did you provide your Supervisor with a written summary of your Grievance?
Yes _____ No _____ If "Yes" on what date? _____

Please include a written copy of the Grievance you submitted to your Supervisor. (Note: **You must submit your grievance in writing to the Hospital's Human Resources Department within 45 days** from the date the grievance occurred or, if the grievance relates to pay, within 45 days after the last day of the pay period the grievance occurred.) Describe your Grievance, include names, dates, places, applicable Contract provisions, what you were told by the Hospital, including your Supervisor, Human Resources and Payroll and all other relevant information.

(Use other side for additional information.)

Signature of Member

Copies of this Form must be sent to:

Association of Diagnostic Imaging Technologists

Brenda Sollars, President & CEO
2351 180th Avenue Northwest
Andover, MN 55304-1368
Telephone: (763) 213-8252
Fax (763) 753-7463
E-mail: xraybrendas@aol.com