ASSOCIATION OF DIAGNOSTIC IMAGING TECHNOLOGISTS

Grievance Form

Name of Member______________________________ **Date**________________
Please Print

Address____
Street City Zip Code

Phone (W)____________ (H)____________ **Hospital**____________________

Name of Supervisor/Manager________________________ **Phone**____________

Date Grievance Occurred__________________________

Have you discussed your Grievance with your Supervisor?____________________
If "Yes" on what date?__________________________

(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.) ***Briefly*** describe your Grievance below:

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Signature of Member

Copies of this Form must be sent to:

1) Association of Diagnostic Imaging Technologists
13750 Crosstown Drive Northwest
Suite 108
Andover, MN 55304-5855
Telephone: (763) 213-8252
Fax: (763) 753-7463

2) Your Human Resources Department

Revised: 01-08