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/Manager?_____
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:

_____

_____

_____

_____

_____

_____

_____

_____

_____
Signature of Member

Copies of this Form must be sent to:

1) Association of Diagnostic Imaging Technologists
807 Broadway Street NE
Suite 127
Minneapolis, MN 55413
Telephone: (763) 213-8252
Fax: (763) 753-7463

2) Your Human Resources Department

Revised: 09-23