

GRIEVANCE STATEMENT

SECTION I – GRIEVANCE INFORMATION: Your grievance must be submitted to the Commission Secretary, along with any written documentation you consider appropriate, within the earlier of: (i) seven (7) calendar days of your receipt; or (ii) ten (10) calendar days of the County and/or District’s deposit in the mail, by **CERTIFIED MAIL, RETURN RECEIPT REQUESTED**; of written notice of the Adverse Personnel Action taken against you. This form should only be used to protest disciplinary suspensions without pay, involuntary demotions or dismissals.

<i>Name and Address of Employee Filing Grievance</i>	<i>Social Security Number</i>	<i>Date You Received Written Notice of Action</i>
	XXX-XX-	
	<i>Telephone Number</i>	
<i>County and/or District Department where employed</i>	<i>Home:</i>	
	<i>Office:</i>	
	<i>Cell:</i>	
<i>Name and Address of Employee Representative (if applicable)</i>	<i>Telephone Number</i>	
	<i>Office:</i>	
	<i>Cell:</i>	
	<i>Fax:</i>	

TYPE OF GRIEVANCE:

- Disciplinary Suspension Without Pay
 Involuntary Demotion
 Termination

I request an: OPEN CLOSED (check one box) hearing.

EMPLOYEE’S SUMMARY OF COUNTY AND/OR DISTRICT ACTION: (Attach any documents you consider relevant to your grievance, including the County and/or District’s written notice to you of the Adverse Personnel Action. Use extra sheets of paper if necessary to fully explain what the County and/or District did).

EMPLOYEE’S SUMMARY OF REASONS EMPLOYEE BELIEVES THE COUNTY AND/OR DISTRICT ACTION IS IMPROPER, INCLUDING SPECIFIC COMMISSION RULE OR RULES VIOLATED: (Use extra sheets of paper if necessary to fully explain why you believe the County and/or District’s action was improper).

REMEDIAL ACTION REQUESTED: (Use extra sheets of paper if necessary to fully explain the relief you seek).

Signature – Employee

Date

ELECTED OFFICIAL/DEPARTMENT HEAD RESPONSE

SECTION II – ELECTED OFFICIAL DEPARTMENT HEAD REVIEW: The Elected Official/Department Head meets with the employee to discuss the grievance; gathers information; enters a response below and meets with the employee to discuss the response, all generally within 14 calendar days after the Elected Official/Department Head receives a copy of the employee’s grievance statement from the Commission Secretary. The Elected Official/Department Head records his or her response to the employee’s grievance below and return the signed form to the Commission Secretary.

<i>Name and Address of Elected Official/Department Head</i>	<i>Date Grievance Received from Commission Secretary</i>	<i>Date of EO's/Dept Head's Review Decision</i>
<i>Name and Address of Elected Official/ Dept. Head Representative (if applicable)</i>	<i>Telephone Number</i>	
	<i>Office:</i> <i>Cell:</i> <i>Fax:</i>	

SUMMARY OF ELECTED OFFICIAL’S/DEPARTMENT HEAD’S RESPONSE: (Use extra sheets of paper if necessary to fully explain your decision).

 Signature – Elected Official/Department Head Date

EMPLOYEE RESPONSE TO SECTION II

SECTION II (CONTINUED) EMPLOYEE RESPONSE: The employee either accepts or appeals the response of the Elected Official/Department Head by checking the appropriate box, signing this form, and returning the original of this form to the Commission Secretary within the earlier of: (i) seven (7) calendar days of the employee's receipt, or (ii) ten (10) calendar days of the deposit in the mail, by CERTIFIED MAIL, RETURN RECEIPT REQUESTED; of the Elected Official's/Department Head's decision from the Commission Secretary. Failure to return the completed form is presumed to be an acceptance of the Elected Official's/Department Head's decision.

I accept the response.

I appeal the response.

PLEASE LIST IN THE COMMENTS ANY SPECIAL ACCOMODATIONS YOU REQUIRE IF A HEARING IS GRANTED, SUCH AS AN INTERPRETER.

COMMENTS: (Use extra sheets of paper if necessary to fully explain your comments).

Signature – Employee

Date

HEAD START POLICY COUNCIL RESPONSE

SECTION III – REVIEW BY HEAD START POLICY COUNCIL: If a Head Start Program employee appeals the response of the Elected Official/Department Head, the Commission Secretary forwards a copy of this form to the Head Start Program Director who forwards it to the Head Start Policy Council. The Council enters its response in Section III of this form and returns the signed form to the Commission Secretary.

<i>Name and Address of Head Start Policy Council Chairperson</i>	<i>Date Grievance Received by Head Start Program Director from Commission Secretary</i>	<i>Date Grievance Received By Policy Council for Action</i>

SUMMARY OF HEAD START POLICY COUNCIL RESPONSE: (Use extra sheets of paper if necessary to fully explain your decision).

Signature – Head Start Program Policy Council Chairperson Date

EMPLOYEE RESPONSE TO SECTION III

SECTION III (CONTINUED) EMPLOYEE RESPONSE: The employee accepts or appeals the response of the Head Start Policy Council by checking the appropriate box, signing this form, and returning this form to the Commission Secretary within the earlier of: (i) seven (7) calendar days of the employee's receipt, or (ii) ten (10) calendar days of the deposit in the mail, by **CERTIFIED MAIL, RETURN RECEIPT REQUESTED**; of the Head Start Policy Council decision from the Commission Secretary. Failure to return the completed form is presumed to be an acceptance of the Head Start Policy Council's decision.

I accept the response.

I appeal the response.

PLEASE LIST IN THE COMMENTS ANY SPECIAL ACCOMODATIONS YOU REQUIRE IF A HEARING IS GRANTED, SUCH AS AN INTERPRETER.

COMMENTS: (Use extra sheets of paper if necessary to fully explain your comments).

Signature – Employee

Date

SECTION IV – FINAL REVIEW BY HEAD START POLICY COUNCIL: If the Commission reverses a decision of the Head Start Policy Council, the Commission Secretary forwards the original of the form to the Head Start Program Director, who forwards it to the Head Start Policy Council. The Council enters its response in this Section IV and returns the signed form to the Commission Secretary.

<i>Name and Address of Head Start Policy Council Chairperson</i>	<i>Date Grievance Received by Head Start Program Director from Commission Secretary</i>	<i>Date Grievance Received By Policy Council for Action</i>

SUMMARY OF HEAD START POLICY COUNCIL RESPONSE: (Use extra sheets of paper if necessary to fully explain your decision)

 Signature – Head Start Program Policy Council Chairperson Date