EMPLOYEE GRIEVANCE APPEAL*
Deaconess Health System, Evansville, Indiana

This form has five parts. *The employee should complete Part 1 and submit it to Human Resources. The Director/Manager then will complete Part 2. Then the employee will complete Part 3. Parts 4 & 5 will be used in the event a hearing is deemed necessary. When corresponding with HR, fax the form to 812-450-2354 or send it to Deaconess Human Resources, 600 Mary Street, Evansville, IN 47747. FORM MUST BE SUBMITTED NO LATER THAN THIRTY (30) DAYS AFTER THE DATE OF THE INCIDENT NECESSITATING A FORMAL COMPLAINT*

PART 1

Employee Name: _____ Department: _____ Location: _____

Job Title: _____ Home Phone: _____

Street Address: _____ City, State, Zip: _____

Statement of problem/complaint (use additional sheets if necessary): _____

Solution Request: _____

Employee Signature: _____ Date: _____

PART 2

Department Director/Manager Response Within 7 Business Days (use additional sheets if necessary)

Director/Manager Signature: _____ Date: _____

PART 3

EMPLOYEE: Please answer the following question and return this form to Human Resources within 10 calendar days: *Does the Director/Manager response above satisfactorily resolve this grievance, or do you wish to pursue a grievance hearing?*

- ❑ The Director/Manager response is satisfactory.
- ❑ The Director/Manager response is unsatisfactory. I wish to pursue a grievance hearing.

Employee Signature: _____ Date: _____

PART 4

Grievance Appeals Committee Recommendation
To Be Submitted To Employee And Department Director/Manager Within 3 Business Days After Hearing

Committee Signatures _____ Date: _____

Panel Secretary Signature _____ Date: _____

PART 5

Administration's Decision
Final Decision To Be Rendered 14 Business Days From Receipt Of The Recommendations Of Grievance Appeals Committee

Administration Official Signature _____ Date: _____

I hereby acknowledge that a copy of this final decision was given to me.

Employee Signature _____ Date: _____