ASSOCIATION OF DIAGNOSTIC IMAGING TECHNOLOGISTS

Grievance Form

Name of Member			
	Please Print		
Home Address			
	Street	City	Zip Code
Phone (W)	(H)	Hospital	
Name of Supervisor		Phone	
Date Grievance occurre	d	_	
Have you discussed you If "Yes" on what date?	nr Grievance with your Superv	isor? Yes	No
	upervisor with a written summ If "Yes" on what d		
Department within 45 pay, within 45 days after your Grievance below:	mit your grievance in write days from the date the grieva er the last day of the pay perio	ance occurred or d the grievance	r, if the grievance relates to occurred.) <i>Briefly</i> describe
			_
		Signature of M	1ember
Copies of this Form m	ust be sent to:		
1) Association of Diagn	ostic Imaging Technologists	2) Your Hu	man Resources Department
13750 Crosstown Driv Suite 108 Andover, MN 55304			
Telephone: (763) 213 Fax (763) 753-7463	-8252		Revised: 01-08