AMERICAN MEDICAL STAFFING

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Employee/Client Grievance Form

Grievant Information

Name:_____Date: _____

Job Title:_____

Contact E-mail: _____

Contact Phone Number: _____

Date, time, and place of event leading to grievance:
Detailed account of occurrence (include names of persons involved, if any):
Please state policies, procedures, or guidelines that you feel have been violated:
Proposed solution to grievance:

The grievant should retain a copy of this form for his/her records. The signature below indicates that you are filing a grievance, and any information on this form is truthful.

_____ _____

Employee/Client Signature Date

_____ _____

Received by Date