

COMMONWEALTH OF VIRGINIA
EMPLOYEE GRIEVANCE PROCEDURE
GRIEVANCE FORM A – Expedited Process

I. Grievance

Employee's Full Name:		* SSN: - -	Job Title:
Agency Code:	Agency Name:		Facility Name:
Home Address:		Work Telephone No. () - ext . Work E-mail Address:	Home Telephone No. () - Home E-mail Address:
Date Grievance Occurred:		Role Title:	
The issues are (use attachments if necessary):			
The facts supporting this are (use attachments if necessary):			
The relief I want is (use attachments if necessary):			
Use of Expedited Process Because (use attachments if necessary):			
Date:	Employee's Signature:		
<p><i>This form may only be used if your complaint involves termination, demotion, suspension without pay, or lost wages. The grievance must be submitted to the second-step respondent unless the grievance alleges discrimination or retaliation by the second-step respondent. In such cases, consult the <u>Grievance Procedure Manual</u> for specific instructions. The Department of Employment Dispute Resolution (EDR) may be contacted if questions arise. . * SSN assists with administrative processing of the grievance and is not required.</i></p>			



II. Second Resolution Step

Date Received:		Date of Meeting:	
Response (use attachments if necessary):			
Date:	Second Step Respondent's Signature:	Telephone No.: () - ext.	
Date Received: _____			
Employee's response (check one):			
<input type="checkbox"/> I conclude my grievance and am returning it to the Human Resources Office.		<input type="checkbox"/> I want the agency head to determine whether I have access to the grievance procedure.	
<input type="checkbox"/> I request qualification of my grievance. . (NOTE THAT ALL EDR RULINGS ARE PUBLISHED ON EDR'S WEBSITE IN A MANNER THAT SEEKS TO PRESERVE PERSONAL PRIVACY		<input type="checkbox"/> I want EDR to rule on whether I initiated my grievance in 30 calendar days	
Employee's comments (optional - use attachments if necessary):			
Date:	Employee's Signature:		
NOTE: The employee is responsible for having the grievance delivered to the proper person or office within five workdays.			

III. Qualification for Hearing/Agency Head

Qualified for a Hearing:	
<input type="checkbox"/> Yes and the agency will request appointment of a Hearing Officer via Form B.	
<input type="checkbox"/> No	
Reasons (use attachments if necessary):	
Date:	Agency Head's Signature:
Date Received: _____	
Employee's response (check one):	
<input type="checkbox"/> I conclude my grievance and am returning it to the Human Resources Office.	
<input type="checkbox"/> I appeal the decision and request the Human Resources Office to forward the grievance record to EDR.	
<input type="checkbox"/> I advance my grievance to hearing and am returning it to the Human Resources Office. (Only check if qualified by agency head)	
Employee's comments (optional - [use attachments if necessary]):	
Date:	Employee's Signature:
NOTE: This form must be returned to the Human Resources Office within five workdays after receipt of the agency head's qualification decision. The agency will retain the original.	

↶ If the agency is not in compliance, a written notice must be sent to the agency head ↷