OREGON FEDERATION OF NURSES AND HEALTH PROFESSIONALS

AFT LOCAL 5017 - AFL-CIO

WORKPLACE INVESTIGATION FORM

Steward's Name_____ Phone#_____ Date_____

Name of Worker_____ Jurisdiction_____

Work Phone #_____ Home Phone #_____

Pony # (if applicable)_____ Home Address_____

Department_____ Immediate Supervisor_____

Classification_____ And Supvr. Phone Number_____

[ ] Part Time [ ] Full Time [ ] Permanent [ ] Probationary

Years of Service_____ Member? [ ] Yes [ ] No

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1. What happened? (the story)_____

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2. Has the contract been violated? If so, what Section?_____

3. When did it happen? When did the worker find out about it?_____

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4. What is the deadline for filing a grievance?_____

5. Who else is affected by this issue?_____
