



Montana Nurses Association

20 Old Montana State Highway • Montana City, MT 56934
(406) 442-6710 Voice • (406) 442-1841 Fax

GRIEVANCE FORM

NAME OF GRIEVANT(S): _____

DEPT. M/S: _____

SHIFT: _____ DAYS: _____ MAILING ADDRESS: _____

PHONE: _____ PERSONAL EMAIL: _____

GRIEVANCE BRIEFLY DESCRIBED: (Include accurate dates, times, and places)

ARTICLE(S) AND SECTION(S) OF THE CONTRACT AND ANY STATUTE(S) VIOLATED INCLUDING BUT NOT LIMITED TO:

REMEDY SOUGHT:

INFORMATION REQUESTED:

Grievant(s) Signature(s): _____

Unit Representative Name:
Address:
Phone:
Email:
Signature:

Date Grievance Filed:
Name of Local Unit:

THIS FORM SHOULD BE FILLED OUT IN TRIPLICATE:

Original to the Grievant(s) Copy to the MNA office Copy to Employer

ALL GRIEVANCES MUST BE TIMELY
(i.e., FILED WITHIN THE TIME FRAMES SPECIFIED IN THE CONTRACT).