New York State Correctional Officers & Police Benevolent Association, Inc.

GRIEVANCE FORM

(Please Type or Print)

Revised: March 1, 2003

LOCAL Grievance Number: _____
Facility (or Agency): _____

DO NOT WRITE IN THIS BOX

NYSCOPBA Grievance Number: CON

Aggrieved Employee: _____

LOCAL Union Rep: _____ **Phone Number/ext.** _____

Date Submitted: _____ **Date of Occurrence:** March 2025

Contract Article Violation(s): Articles 2, 6, 8, 14, 31 and 27 (Civil Ser. Law §§ 161, 161a, 162; FMLA, NY Workers Comp Law)

STATEMENT OF FACTS:

On March ___ 2025, I received notice from the New York State Department of Corrections and Community Supervision (DOCCS) that I was terminated effective March 2025 pursuant to Article 14.10 of the Agreement. Article 14.10 of the Agreement states, "Any employee absent from work without authorization for ten (10) consecutive workdays shall be deemed to have resigned from his position if he has not provided a satisfactory explanation for such absence on or before the eleventh (11th) workday following the commencement of such unauthorized absence."

Contrary to the assertion in the March , 2025, letter, I provided a satisfactory explanation to DOCCS for my absence from work. Specifically, _____

_____

Documentation supporting the reason for the absence, fully explaining the reasons for my absence from work, and all other communications with the facility during the relevant time is attached to this grievance.

By terminating my employment, after providing sufficient explanation for my absence, DOCCS violated Article 14.10 of the Agreement. Further, by terminating my employment without any due process under Article 8, which includes the right to an arbitration hearing and a determination on "just cause" DOCCS violated Article 8 of the Agreement.

REMEDY SOUGHT: That this grievance be sustained; that the March XX 2025 letter terminating my employment be rescinded; that I be immediately reinstated to employment with DOCCS in my former position and title; that I be awarded full back pay, and benefits, retroactive to the date of termination; that I be made otherwise whole for any losses suffered from my improper termination of employment; to have my healthcare insurance re-instated and to be reimbursed to payments for the Employer's Share of Healthcare Insurance. _____

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_____

Aggrieved Employee's Signature:_____

STEP I DECISION

Date of Review:_____

Date Received:_____

Superintendent or Designee:_____ **Date Answered:**_____

Date Received:_____

Received by (Union Official):

APPEAL TO STEP II

FACTS OF APPEAL:_____

Signature:_____ **Date Appealed:**_____