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:**_____

Contract Article Violation(s): Articles 14, 27 (Workers' Compensation Law section 120) (Attendance and Leave Manual) (FMLA)

STATEMENT OF FACTS:

On _____, 2025, _____ issued a direct order to me to report to the _____ Correctional Facility for duty at _____.

On _____ I sustained a work-related injury while on duty. Based upon this injury, I have an established Workers' Compensation Claim. Documentation supporting my Workers' Compensation Claim is attached.

My treating medical provider found that I was necessarily absent from duty due to this injury for the period of [Insert Dates initial disability and end of disability] Supporting medical documentation is attached.

Article 14.9 of the Agreement provides that Employees necessarily absent from duty because of an occupational injury as defined by Workers' Compensation Law, shall be entitled to 6 months of compensation leave without charge to accruals, then may exhaust unused accruals, then may be entitled to sick leave at half pay.

Workers' Compensation Law section 120 prohibits discrimination and/or retribution for filing a Workers' Compensation Claim.

By ordering me to return to duty, during a time period when my treating provider found me totally disabled from duty due to an established Workers' Compensation injury, DOCCS violated Article 14 of the Agreement, New York Workers' Compensation Law, New York Civil Service Law and/or the Family Medical Leave Act.

REMEDY SOUGHT: **That this grievance be sustained; that I be immediately permitted to return to Workers' Compensation Leave; that if DOCCS assessed any Absent Without Leave (AWOL) charges against me while I was absent on Workers' Compensation Leave, that such AWOLs be rescinded and that I be paid in full for all AWOL dates; and that I be made whole for any losses.**

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:**_____