



TEAMSTERS LOCAL 2785 THE E-Z OVER 9.5 HOUR GRIEVANCE FORM

FAX: (415) 467-5677

NAME HOME/CELL PHONE CENTER

ADDRESS CITY ZIP CODE

I have been required by United Parcel Service to work over nine and one-half (9 1/2) hours over fifty percent (50%) of the time, during the week ending ____ / ____ / ____ as follows below:

(Total hours worked excluding lunch period)

Mon ____ / ____ Hours ____ Minutes ____ Route # ____ Check if extra work was added

Tues ____ / ____ Hours ____ Minutes ____ Route # ____ Check if extra work was added

Wed ____ / ____ Hours ____ Minutes ____ Route # ____ Check if extra work was added

Thurs ____ / ____ Hours ____ Minutes ____ Route # ____ Check if extra work was added

Fri ____ / ____ Hours ____ Minutes ____ Route # ____ Check if extra work was added

Cover drivers indicate what route you drove for entire week or for each day if different.

Did management honor your seniority in the dispatching of routes? If not indicate:

Route #	Day	Supervisor/Manager	Less Senior Driver
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I am requesting that my hours be reduced per Article 37 Section 1(c) of the National Master United Parcel Service Agreement.

Signature Date

FOR OPT IN PURPOSES:

Opt In Date: _____ Driver Initials: _____ Steward Initials: _____ Manager Initials: _____