Staffing Issue Form – Kaleida Health

Effective 11/1/2019

Employee Section:
Please complete this page within 24 hours of the staffing issue. Submit a copy to your manager and union office.
*Please submit one form per shift per unit*

Date of staffing issue: ___________________ Department: ___________________

Shift: ___________________ Census: ___________________ (if applicable)

<table>
<thead>
<tr>
<th>List Job Title(s)</th>
<th>Regular Staff</th>
<th>Float Staff</th>
<th>Agency</th>
<th># per Staffing Plan</th>
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Brief description of staffing issue:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name of Manager/Supervisor notified: ___________________ Time of notification: ______________

Was the staffing issue resolved? Yes ______________ No ______________

To your knowledge, what actions were taken by all to resolve the staffing issue?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Respectfully Submitted by: ____________________________

Date submitted: ___________________ Time submitted: ___________________
Manager Section:
Please complete this section within 72 hours from receipt of form and return a copy of this entire form to the employee.

Was the shift staffed correctly? Yes ______ No ______ if no, why?

Date schedule was finalized/posted: ________________________
What occurred after the schedule was posted to negatively impact staffing?

# Call-Offs/PTU/Intermittent FMLA: ___________ # on Approved PTO: ______________________
# of LOA, DBL, W/C: ___________ Other ______________________
What actions were taken to resolve the issue and why were they unsuccessful?

Comments:

Name of management completing form: ______________________
Date & Time completed: ______________________

Fax a copy of this form to the applicable offices:
Nursing Office /Department Manager: BGH 859-7443, MFS 568-3127, DMH 690-2300, OCH 323-1382,
Flint 626-7274, HighPointe 748-3166. Union Offices: 1199 SEIU 876-0930, CWA 636-9100