



## **EMPLOYEE GRIEVANCE FORM**

This form is to be filled out by an employee who is dissatisfied with an aspect of his/her treatment for an occupational injury. By completing this form, you are filing a grievance which will be reviewed and addressed by members of our administrative staff. Every effort will be made to accommodate reasonable requests.

Please submit your written statement on the following lines within thirty (30) days of the occurrence of the event giving rise to the grievance. OMCA will render a written decision within thirty (30) days of receipt of this grievance.

FACILITY WHERE YOU WERE TREATED \_\_\_\_\_

NAME OF DOCTOR THAT TREATED YOU \_\_\_\_\_

DATE OF OCCURRENCE \_\_\_\_\_

COMPLAINT \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I agree to allow administrative staff to discuss my complaint with the provider(s) in questions.

Company Name \_\_\_\_\_

Your Name (please print) \_\_\_\_\_

Address \_\_\_\_\_  
*Street address* *City* *State* *Zip*

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE RETURN TO:**  
**Occupational Managed Care Alliance, Inc.**  
**Attention: Client Services Department**  
**Post Office Box 20908**  
**Louisville, Kentucky 40250-0908**