



Community Subsector Collective Agreement CLASSIFICATION REVIEW FORM

Name of Person(s) Initiating this Review Request: _____

If the review is for more than one employee please provide a complete list of claimants using additional pages if necessary

Home Address: (Street, City, Prov, PC): _____

Phone: Home: _____ Work: _____ Cell: _____

Home Email: _____ Work email: _____

Employee Status: ☐ Full-Time ☐ Part-Time ☐ Casual

Current Job Title: _____ Grid: _____ Wage Rate: _____

Employer: _____

Location / Program / Worksite: _____

Current Benchmark Title(s): _____

I (we) submit that the above-noted job is inappropriately matched and more appropriately matches:

(Benchmark Title)

Reasons for job's present classification being inappropriate: (Use additional pages if necessary):

Signature of person(s) initiating this review request: _____

**In accordance with the Maintenance Agreement, Clause 7.3 the Employer must review this
Classification Review Form and notify the Union and HEABC of its determination
in writing within 30 calendar days.**

Employer Received Classification Review Form on (Date): _____

GENERAL INSTRUCTIONS

To request a classification review, please complete this form and email it along with your job description (if available) to each of the following:

1. Employer / Agency
2. Union Headquarters: c/o Community Health Classifications, BCGEU
via email: commhealth.classifications@bcgeu.ca; or via "Email to Union" on PDF form