

LIBERTY UNIVERSITY[®]

COLLEGE *of* OSTEOPATHIC MEDICINE

GRIEVANCE HEARING REQUEST FORM

Name of Grievant: _____

OMS: _____

Date of Adverse Action: _____

Statement of Grievance

(Please describe in detail your specific complaint)

Requested Remedy

(Please specify what actions you are seeking in order to resolve your complaints)

Grievant Signature

Date