CLASSIFICATION MAINTENANCE REVIEW
STATE OF DELAWARE

CLASSIFICATION APPEAL FORM

SECTIONS TO BE COMPLETED BY AGENCY PERSONNEL

Position Number:_____
Department/Division/Section:_____
Date Employee was Given Notice of the Classification Decision by the Agency:_____
Date Appeal was Submitted by Employee:_____
Name of Personnel Representative:_____
Title:_____ Phone No._____ Fax No._____
Date Bargaining Unit Representative Notified of Appeal (if applicable):_____

Note: Items 1-4 are to be completed by the employee who is appealing the classification decision. Items 5-7 are to be completed by the Division Director and/or the appropriate agency manager who is knowledgeable of the duties and responsibilities of the employee in this position.

TO BE COMPLETED BY EMPLOYEE

1. **Name**: _____

   Mailing Address - Workplace: _____
   (Include State Mail Code, if known)_____

   Mailing Address - Home (optional):_____
   _____

   Work Phone No._____ **Work Fax No.**_____

   Class Title: _____
   (Former Title)

   _____
   (New Title)

Date Employee was Given Notice of the Classification Decision by the Agency:_____

Agency:_____

2. Grounds for classification appeal. (See guidelines for classification appeals to the Merit Employee Relations Board).

A._____ One or more major duties and responsibilities or major knowledge, skills and abilities are not included in the class specification.

B._____ Another class specification is clearly a more accurate description of the position.

3.A. If you checked 2(A) or 2(B) above, list the duties and responsibilities that are assigned to your position that are not included in the new class specification.

3.B. If you checked 2(A) or 2 (B) above, list the knowledge, skills and abilities that are required for your position that are not included in the new class specification. (Please note: personal qualifications and job performance of employees are not relevant factors in classifying positions).

4. Relief sought (check one of the following):

   1._____ Revisions to class specifications.
   2._____ Reclassification of position to: _____
   Name of Classification

(If No.2 was checked, the requested class title must be listed.)

****

TO BE COMPLETED BY AGENCY MANAGER OR DIVISION DIRECTOR

5. Name of Manager:_____
   Phone No. _____Fax No._____
   Title:_____

6. If the employee completed section 3(A), please verify that each of the duties and responsibilities listed are assigned to the position. How long have these duties been assigned to this position? If possible, indicate the specific date these duties were assigned.

If the employee completed section 3(B), please verify that the knowledge, skills and abilities listed are required to perform this job. (Please note: Personal qualifications and job performance of employees are not relevant factors in classifying positions).

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EMPLOYEE **DATE**

IMMEDIATE SUPERVISOR **DATE**

DIVISION DIRECTOR **DATE**

PERSONNEL REPRESENTATIVE **DATE**

Appeal form adopted by the Merit Employee Relations Board: June 19, 1997
Revised: April, 2004