Inquiry Form – Collective Grievance – Mandatory overtime

SECTION I

Name of employee and employee number:			
Job title:			
Status:		**Number of days/14 days:**	
Centre of activities:		**Date of regular shift:**	
Shift (day, evening, night):			
Time regular shift begins and ends: to			
Overtime and mandatory overtime (recurrence)			
a. How often have you worked overtime in the last two weeks?			
b. How often have you worked mandatory overtime in the last two weeks?			
MOT DETAILS:			
1. The date of the MOT:			
2. How long was the MOT? h mins			
3. The time of the notice to work this MOT:			
4. Was the MOT imposed because of an emergency, an exceptional, unforeseen situation?		Yes ◯ No ◯	
If yes, why?			
5. Was the MOT caused by replacement needs known in advance? Yes ◯ No ◯			

6. Why? (Check all choices that apply)

☐ Additional needs for healthcare professionals not filled (work overload).
☐ Absences were not all replaced (absences).
☐ There are not enough regular positions on my centre of activities (lack of positions).
☐ Vacant positions not filled.

7. Did the Employer try everything to avoid using MOT?	Yes ◯ No ◯
a. Contact employees on the availability list (straight time)	Yes ◯ No ◯
b. Contact employees on the availability list (time and ½, double time)	Yes ◯ No ◯
c. Reorganize the work	Yes ◯ No ◯
d. Limit services (stop admissions, close beds, etc.) Other limits:	Yes ◯ No ◯

Do you know if the Employer could have taken other steps?
Use the reverse side if necessary.

Describe the circumstances of the MOT in a few lines (your version of the facts):

8. The name of the person who asked you to work MOT and her function:

Name:

Function:

You must send a copy of your schedule and attendance record within 30 days of working the MOT, at the latest.

The information recorded on this document is essential to take the collective grievance denouncing the MOT further. It must be accurate and complete. Moreover, Section 2 of this form is optional, but could be used to establish your rights to an eventual indemnity.

SECTION II

- **CONSEQUENCES ON THE HEALTHCARE PROFESSIONAL**

OPTIONAL PART: YOU ARE NOT OBLIGED TO COMPLETE THIS SECTION BUT WE SUGGEST THAT YOU DO

Break time and meal period

Regular shift

1. I took my meal break: Yes ◯ No ◯ If yes at:
2. I took my last break: Yes ◯ No ◯ If yes at:

MOT shift

3. I took my meal break: Yes ◯ No ◯ If yes, I took my meal at:
4. I took my last break: Yes ◯ No ◯ If yes, I took my last break at:

5. What is the impact and consequences of this MOT on my family, parental or personal obligations?

6. I was in charge of (number) patients for my regular shift and I had (number) when I worked mandatory overtime.

7. During my MOT shift, there was: (Check all choices that apply)
   - ☐ Non-replacement
   - ☐ Substitutions of job titles
   - ☐ A healthcare professional from another centre of activities
   - ☐ Independent labour
   - ☐ A contingency plan applied

8. I asses my level of fatigue:

Not tired — Moderately tired — Very tired

1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯

9. I informed my employer about my level of fatigue Yes ◯ No ◯
10. My employer took my level of fatigue into account Yes ◯ No ◯

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"I hereby agree that my Union and its authorized representatives collect, use, keep and communicate, in carrying out their duties, the personal information sent in order to defend my rights and represent me." ☐