



Complaint Number: _____

Complaint Form, Including Discrimination Complaints

Use this form to file a complaint, including discrimination complaints, with the Division of Equal Opportunity Development. The complaint may be against: a public or private employer, employee, company, or agency, including the New York State Department of Labor or other individuals or entities. Your name and information will be kept confidential to the fullest extent of the law.

For more information go to: https://www.labor.ny.gov/equal-opportunity or call: (518) 457-9000 or (888) 469-7365. Call (800) 662-1220 for TTY/TTD. People with Disabilities may use the New York State Relay services. In NYC, dial 211; in all other parts of the State, dial 711.

Instructions: You must file your complaint against Workforce Innovation and Opportunity Act (WIOA) recipients within 180 days from when the incident happened. Human Rights Law however states that a complaint can be filed within a full year from the date of the occurrence.

- For all complaints, please complete numbers 1 through 7 and number 13.
If you feel you have been discriminated against, please complete numbers 1 through 13.
Mail the completed and signed form and any supporting documents to the address above.
Note: The person making the complaint, or their representative (see number 10), must sign and date number 13.
If needed, the person handling your complaint will help you fill out this form.

1. Complainant information (Person making the complaint):

First name: _____ MI: ____ Last name: _____
Address: _____
City: _____ State: ____ Zip: _____
Social Security Number: ___ - ___ - _____ Home phone: (____) _____ Work phone: (____) _____
E-mail address: _____
Are you a New York State Department of Labor employee? [] Yes [] No

2. Respondent information (Agency, employer, or employee you are complaining about):

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: (____) _____

3. What is the most convenient time for us to contact you about this complaint? _____ [] A.M. [] P.M.

4a - 4d. Briefly describe your complaint. Be as clear as possible. If you believe you were discriminated against, please describe how, in detail. Attach additional sheets, if needed. Also, attach any written material relating to your case.

4a. What happened? Please include where it happened.

4b. Who was involved? Include witnesses, fellow employees, supervisors or others. Provide name, address and phone number, if known.

4c. When did it happen, on what date? _____

4d. How were you treated differently?

5. How would you like this complaint to be resolved?

6. Were you offered employment services? Yes No

7. **Do you feel you have been discriminated against?** Yes (If "Yes," complete numbers 1 through 13)
 No (If "No," skip to number 13)

8. How were you discriminated against? Check all that apply and enter requested information.

- | | |
|---|---|
| <input type="checkbox"/> Race (specify): _____ | <input type="checkbox"/> Genetic predisposition & carrier status (specify): _____ |
| <input type="checkbox"/> Color (specify): _____ | _____ |
| <input type="checkbox"/> Religion (specify): _____ | <input type="checkbox"/> Veteran status (specify): _____ |
| <input type="checkbox"/> National Origin (specify): _____ | <input type="checkbox"/> Age (Enter date of birth): _____ |
| <input type="checkbox"/> Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Sexual orientation: _____ |
| <input type="checkbox"/> Arrest & conviction record (specify): _____ | <input type="checkbox"/> Political affiliation (specify): _____ |
| <input type="checkbox"/> Disability (specify): _____ | <input type="checkbox"/> Victim of Domestic Violence: _____ |
| <input type="checkbox"/> Marital status (specify): _____ | <input type="checkbox"/> Reprisal/retaliation (specify): _____ |
| <input type="checkbox"/> Citizenship (specify): _____ | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Sexual harassment: _____ | _____ |

9. Why do you think this happened? _____

10. Do you have an attorney or other representative for this complaint? Yes No

If "Yes," please enter their information below:

Name: _____ Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.

Complaint Number:

11. Have you filed a case or complaint about this incident with any of the following?

- US Department of Justice, Civil Rights Division
- NYS Department of Labor, Division of Equal Opportunity Development
- US Equal Employment Opportunity Commission
- NYS Division of Human Rights
- US Department of Labor, Civil Rights Center
- Federal or State Court
- Other: _____

12. For each agency checked in number 11, please enter the following information:

Agency: _____
Date filed: _____
Case or docket number: _____
Date of trial or hearing: _____
Location of agency or court: _____
Name of investigator: _____
Status of case: _____
Comments: _____

Agency: _____
Date filed: _____
Case or docket number: _____
Date of trial or hearing: _____
Location of agency or court: _____
Name of investigator: _____
Status of case: _____
Comments: _____

Agency: _____
Date filed: _____
Case or docket number: _____
Date of trial or hearing: _____
Location of agency or court: _____
Name of investigator: _____
Status of case: _____
Comments: _____

Agency: _____
Date filed: _____
Case or docket number: _____
Date of trial or hearing: _____
Location of agency or court: _____
Name of investigator: _____
Status of case: _____
Comments: _____

13. **I certify** that the information above is true and accurate to the best of my knowledge.
I authorize the disclosure of this information to enforcement agencies for the investigation of my complaint.
I understand that my identity will be kept confidential to the maximum extent possible consistent with applicable law(s).

Complainant's Signature or Representative's Signature (see number 10): _____ Date: _____

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.
This is the end of the complaint form. Do not write below this line.

----- **For New York State Department of Labor Staff Only** -----

A. Type of complaint. Check all that apply: Wage related Pesticides Child labor Health/Safety
 Working conditions Housing Discrimination Other: _____

B. ES related? Yes No If "Yes," Job Order Number: _____
 Against employment service? Against employer? Alleged violation of ES regulations?
 Alleged violation of employment laws?
 MSFW with complaint concerning laws enforced by NYS Labor Standards or OSHA?

C. MSFW? Yes No

D. Out of state employer? Yes No

E. H-2A/Criteria employer? US domestic worker H-2A worker Wages Housing
 Transportation Meals Other (specify): _____

F. Referred to: NYS EO Officer ESA OSHA NYS Monitor Advocate
 NYS Labor Standards Other: If "Other," enter the following information:
Agency name: _____ Phone: (____) _____
Address: _____ City: _____ State: ____ Zip: _____

G. Follow up? Yes No If "Yes," Monthly Quarterly Follow up date: _____
Comments: _____

Complaint received by: _____ Title: _____
Office: _____ Phone: (____) _____
Signature: _____ Date: _____

----- **For United States Department of Labor Staff Only** -----

H. **Case Number:** _____

CIF received by CRC: Accepted Not accepted

Comments: _____

Received by: _____ Date: _____
Signature: _____ Date: _____

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request to individuals with disabilities.