Division of Equal Opportunity Development
Harriman State Office Campus
Building 12, Room 540
Albany, NY 12240

WE ARE YOUR DOL

NEW YORK STATE | Department of Labor

www.labor.ny.gov

Complaint Number: _____

Discrimination Complaint Information Form

Use this form to file a discrimination complaint with the Division of Equal Opportunity Development. The complaint may be against: a public or private employer you were referred to by the New York State Department of Labor, or against the New York State Department of Labor or its employees, and recipients of federal funding under the Workforce Innovation and Opportunity Act (WIOA) for allegations of discrimination in relation to their programs, services, and activities. Your name and information will be kept confidential to the fullest extent of the law.

For more information go to: https://dol.ny.gov/equal-opportunity or call: (518) 457-9000 or (888) 469-7365. People who are Deaf, Hard of Hearing, DeafBlind or those with Speech Disability can call the New York State Relay Service at (800) 662-1220 for TTYITTD, 211 in NYC, or 711 in other parts of the State.

Instructions:

- 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 you need help completing this form, you may contact DEOD at 518-457-1984.
  NOTE: Workforce Innovation and Opportunity Act complaints must be filed within 180 days of the date the incident occurred.

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.

_____

_____

_____

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

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.

☐ Race (specify): _____
☐ Color (specify): _____
☐ Religion (specify): _____
☐ National Origin (specify): _____
☐ Sex: ☐ Male ☐ Female ☐ X
☐ Arrest & conviction record (specify)_____
☐ Disability (specify):_____
☐ Marital status (specify): _____
☐ Citizenship (specify): _____
☐ Sexual harassment: _____
☐ Genetic predisposition & carrier status (specify): _____
☐ Veteran status (specify): _____
☐ Age (Enter date of birth): _____
☐ Sexual orientation: _____
☐ Political affiliation (specify): _____
☐ Victim of Domestic Violence: _____
☐ Reprisal/retaliation (specify): _____
☐ Other (specify): _____

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:_____

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____

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: ______________________
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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: ______________

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This is the end of the complaint form. Do not write below this line.

This page is for official use only.

Complaint Number: _____

---------- 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: _____

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