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://dol.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 Investment Opportunities 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.
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________
   ________________________________________________________________________________________________

Equal Opportunity Employer/Program
Auxiliary aids and services are available upon request 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): ___________________________  □ Genetic predisposition & carrier status (specify):
□ Color (specify): ___________________________  □ Veteran status (specify): ______________________
□ Religion (specify): _________________________  □ Age (Enter date of birth): _________________
□ National Origin (specify): ___________________  □ Sexual orientation: _________________________
□ Sex: □ Male □ Female  □ Political affiliation (specify): ______________________
□ Arrest & conviction record (specify): ________  □ Victim of Domestic Violence: ______________
□ Disability (specify): ______________________  □ Reprisal/retaliation (specify): _______________
□ Marital status (specify): ___________________  □ Other (specify): __________________________
□ Citizenship (specify): ______________________
□ Sexual harassment: ________________________
□ Sexual orientation: ________________________

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:

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<th>Agency</th>
<th>Date filed</th>
<th>Case or docket number</th>
<th>Date of trial or hearing</th>
<th>Location of agency or court</th>
<th>Name of investigator</th>
<th>Status of case</th>
<th>Comments</th>
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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: _____________
This page is for official use only.

-------------------------- 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

□ 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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