



Complaint Information Form

Instructions: Please complete Questions 1-7. If you feel you have been discriminated against, also fill out Questions 8-12. When you are done, go to Question 13, sign and date. If needed, the person handling your complaint will assist you in completing this form. Send to: NYS Department of Labor, Division of Equal Opportunity Development, State Office Campus, Building 12, Room 540, Albany, N Y 12240.

1. Complainant First name _____ MI _____ Last name _____
Address _____ City _____ State _____ Zip _____
SSN _____ Home telephone (_____) _____ Work telephone (_____) _____
E-mail address _____ Are you a NYS DOL employee? Yes No

2. Respondent Agency, employer or employee you are making complaint against _____
Address _____ City _____ State _____ Zip _____
Telephone (_____) _____

3. What is the most convenient time for us to contact you about this complaint? _____

4. Briefly describe as clearly as possible your area of concern. If you believe you were discriminated against, please describe in detail how you were discriminated against. Attach additional sheets if required. Also, attach any written material pertaining to your case.

a. What happened? _____

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

c. When did it happen (include date)? _____

d. 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 No If "Yes," answer # 8 - 12. If "No," go to #13.

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

9. Why do you believe these events occurred? _____

10. Do you have an attorney or other representative for this complaint? Yes No If "Yes," please provide the following:
Name _____ Telephone (_____) _____
Address _____ City _____ State _____ Zip _____

11. For this incident, have you filed a case or complaint with any of the following?
 US Dept. of Justice, Civil Rights Division NYS Dept. of Labor, Division of Equal Opportunity Development
 US Equal Employment Opportunity Commission NYS Division of Human rights
 US Dept. of Labor, Civil Rights Center Federal or State Court
 Other _____

12. For each agency checked in #11, please provide the following information:

Agency _____ Date filed _____
Case or docket no. _____
Date of trial or hearing _____
Location of agency or court _____
Name of investigator _____
Status of case _____
Comments _____

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13. I certify that the information furnished above is true and accurately stated to the best of my knowledge. I authorize the disclosure of this information to enforcement agencies for the proper investigation of my complaint. I understand that my identity will be kept confidential to the maximum extent possible consistent with applicable law and a fair determination of my complaint.

Complainant Signature

Date

For New York State Department of Labor Staff Only

14. Type of complaint. Check **all** that apply. Wage related Pesticides Child labor
 Health/safety Working conditions Housing
 Discrimination Other _____

15. 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?

16. MSFW? Yes No

17. Out of state employer? Yes No

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

19. Referred to NYS EO Officer ESA OSHA
 NYS Monitor Advocate NYS Labor Standards Other _____

If "Other," agency name _____ Telephone (____) _____
Address _____ City _____ State _____ Zip _____

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

21. Person receiving complaint _____ Title _____
Office _____ Telephone (____) _____

Signature

Date

For United States Department of Labor Staff Only

22. Case Number _____

CIF received by CRC Accepted Not accepted

Comments _____

Received by

Date