

Complaint of Discrimination in Employment
Under Federal Government Contracts

U.S. Department of Labor
Office of Federal Contract
Compliance Programs



Un

Instructions: Before completing this form, please read all instructions, including the Privacy Act statement below. Use this form to file a complaint of discrimination in employment under any of the OFCCP programs. While your response is voluntary, OFCCP relies on this information as a source for identifying potential violations of equal employment opportunity requirements in the federal contractor community. Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No: 1250-0002

Expires:

Privacy Act Notice: The authority for collecting this information is Executive Order 11246, as amended, Sec. 503 of the Rehabilitation Act of 1973, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974 as amended, 38 U.S.C. 4212; Title VII of the Civil Rights Act of 1964, as amended; and/or Title I of the Americans with Disabilities Act of 1990, as amended (ADA). This information is used to process complaint and conduct investigations of alleged violations of the above Order or Acts. We will provide a copy of this complaint to the employer against whom it is filed and, when matters alleged are covered by Title VII and/or the ADA, to the U.S. Equal Employment Opportunity Commission (EEOC). The information collected may be verified with others who may have knowledge relevant to the complaint. It may be used in settlement negotiations with the employer or in the course of presenting evidence at a hearing, or may be disclosed to other agencies with jurisdiction over the complaint. Providing this information is voluntary; however failure to provide the information will restrict the action that the Department of Labor can take on your behalf and, for matters covered by Title VII or the ADA, may affect your right to sue under those laws.

Non-Retaliation: OFCCP regulations and Title VII and/or the ADA where applicable, require an employer to take all necessary steps to assure that there is no retaliation against any person who files a complaint or assists in its investigation. This includes any intimidation, threat, coercion or discrimination. Please notify OFCCP immediately if any alleged attempt at retaliation is made.

Prompt Filing: All complaints must be filed within a specified number of days following the latest occurrence of the alleged discrimination: Executive Order 11246 – 180 days; Rehabilitation and Veterans Acts – 300 days. Exceptions must be approved by the Director.

Name and address: Name _____ Address _____ City _____ State _____ Zip _____	Name and address of company you allege discriminated against you: Name _____ Address _____ City _____ State _____ Zip _____
Telephone No. _____	Telephone No. _____
Mail this form to the Department of Labor, OFCCP Regional Office:	Give the date(s) of the latest occurrence(s) of the alleged discriminatory act(s): _____

Step 1: Check the box next to the program you are filing under (i.e. Executive Order 11246, as amended; Section 503 of the Rehabilitation Act of 1973, as amended, or the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212, or retaliation)

Step 2: Under the program, check what you believe to be the basis for the discrimination against you, such as race, sex, or national origin. If you think that there was more than one basis, more than one basis may be checked. You may also check more than one race/ethnic category.

Executive Order 11246, as amended. This Order covers persons alleging discrimination because of race, color, religion, sex, or national origin. If this is checked, your complaint will be dual filed as a charge under Title VII of the Civil Rights Act of 1964. I believe I was (or continue to be) discriminated against because of my:

Bases:

- | | | |
|--|---|--|
| <input type="checkbox"/> Race | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> American Indian or Alaskan Native |
| <input type="checkbox"/> Color | <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Religion | | <input type="checkbox"/> Black or African American |
| <input type="checkbox"/> Sex <input type="checkbox"/> Female <input type="checkbox"/> Male | | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> National Origin | | <input type="checkbox"/> White |
| <input type="checkbox"/> Other | | |

Section 503 of the Rehabilitation Act of 1973, as amended. This Act covers individuals with a disability, persons with a history of physical or mental disability, and persons regarded as disabled by the employer. If this is checked, your complaint will be dual-filed as a charge under the Americans with Disabilities Act.

Basis Disability Please check if you are a veteran: Yes No

Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, 38 U.S.C. 4212. This Act covers special disabled veterans, veterans of the Vietnam Era, recently separated veterans, disabled veterans, Armed Forces service medal veterans, and other protected veterans.

Retaliation: It is unlawful to harass, intimidate, threaten, coerce, or discriminate against any individual because he or she has filed a complaint, participated in a discrimination proceeding or otherwise opposed discrimination under any of the federal programs above.

Form CC-4

IF YOUR COMPLAINT IS BASED ON VETERAN STATUS, CHECK ONE OR MORE OF THE FOLLOWING APPLICABLE BOX(ES).

I was discharged or released from active duty on (enter date of discharge or release) _____

I am a veteran who, while serving on active duty in the Armed Forces, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985 (61 CFR 1209).

I served on active duty during a war or in a campaign or expedition for which a campaign badge has been authorized.

I served on active duty for a period of more than 180 days, and was discharged or released with other than a dishonorable discharge, and the active duty occurred in the Republic of Vietnam between February 28, 1961, and May 7, 1975; or between August 5, 1964, and May 7, 1975 in all other cases.

I was discharged or released from active duty for a service connected disability. If you have checked this box, submit medical information resulting in discharge or release with this form. (This information is available from your Master Military Record at the National Personnel Record Center, 9700 Page Boulevard, St. Louis, MO 63132.)

I am a veteran who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs. Check one of the following:

Disability rating of 30% or more

Disability rating at 10% or 20% and have been officially determined to have a serious employment disability

Disability rating, but neither a or b

Step 3: Check those actions which you believe the employer took or failed to take because of your race, color, religion, sex, national origin, disability or veteran status (more than one may be checked):

Issue(s):

- | | | | |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Hiring | <input type="checkbox"/> Promotion | <input type="checkbox"/> Job Assignment | <input type="checkbox"/> Sabbath Day Observance |
| <input type="checkbox"/> Termination | <input type="checkbox"/> Demotion | <input type="checkbox"/> Training and Apprenticeship | <input type="checkbox"/> Intimidation |
| <input type="checkbox"/> Layoff | <input type="checkbox"/> Seniority | <input type="checkbox"/> Segregated Facilities | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Recall | <input type="checkbox"/> Harassment | <input type="checkbox"/> Pregnancy Leave | |
| <input type="checkbox"/> Wages | <input type="checkbox"/> Job Benefits | <input type="checkbox"/> Accommodation to Disability | |

FOR EACH ISSUE, EXPLAIN IN YOUR STATEMENT BELOW HOW YOU WERE DISCRIMINATED AGAINST.

1. Do you know any other employees or applicants of your group who were treated in the same way (checked above) you allege you were?

Yes No If yes, include their names in your statement below and explain how they were treated.

2. Do you know any other employees or applicants who are not of your group who were treated in the same way (checked above) you allege you were?

Yes No If yes, include their names in your statement below and explain how they were treated.

THE COMPLAINT

Describe in detail the alleged discriminatory/retaliatory act (s).

Please include:

- Why you believe the act(s) was because of your disability, veteran status, race, color, religion, sex, or national origin, and why you believe the act(s) was retaliation;
- Dates, places, names and titles of persons involved and witnesses, if any;
- What harm, if any, was caused to you or others with whom you work as a result of the alleged discriminatory act(s);
- What explanation, if any, was offered for the act(s) by the employer; and
- Any information you may have on federal contracts held by the employer.

If this is a complaint based on disability, describe the disability, your history of disability, or why you think the employer regarded you as disabled.

(Type as much information as required into the block above)

If you have sought assistance in resolving this complaint from another source (another agency, a lawyer, internal grievance procedure, etc.) please indicate here and the name of the source, the date you sought assistance, and result, if any:

Name _____	Date _____
Result: _____	

FRIEND OR RELATIVE:

Please notify OFCCP if you change your address or phone number. You may indicate a person who would know how to reach you if OFCCP is unable to reach you at your own address or phone.

Name _____

Address _____

City _____ State _____ Zip _____

Relationship _____

Telephone _____

<p>FILED ELSEWHERE? If you have filed this complaint or a similar one elsewhere, please tell us:</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Contact _____</p> <p>Telephone _____</p>	<p>ARE YOU REPRESENTED? If you are represented by an attorney or other person or organization, please tell us:</p> <p>Name _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Contact _____</p> <p>Telephone _____</p>
--	--

SIGNATURE AND VERIFICATION

I declare under penalty of perjury that the information given above is true and correct to the best of my knowledge or belief. (A willful false statement is punishable by law: 18 U.S.C. 1001.) I hereby authorize the release of any medical information needed for the investigation.

Signature of Complainant

Date

Public Burden Statement

We estimate that it will take an average of 1.28 hours to complete this complaint form, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this complaint form, including suggestions for reducing this burden, send them to the Office of Federal Contract Compliance Programs Policy Division (1250-0002) 200 Constitution Avenue, N.W., Room C3310, Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Do not write below this line

The complainant has verified this complaint in my presence. This complaint is now the basis of an investigation under Executive Order 11246, as amended; Section 503 of the Rehabilitation Act of 1973, as amended; and/or the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended (38 U.S.C. 4212).

Name of Investigator

Title

Signature of Investigator

Date