



Complaint Involving Employment Discrimination by a Federal Contractor or Subcontractor

OMB: 1250-0002
Expires: XX/XX/XXXX

Please read the instructions before completing this form.

How can we reach you?	Name (First, Middle, Last): _____ Street Address: _____ City, State, Zip Code: _____ Telephone Number: _____ Home _____ Work _____ Cell _____ Email: _____ Have you filed these allegations of employment discrimination with another federal or local agency? _____ Yes _____ No If yes, which agency: _____ Contact Name: _____ Phone Number: _____				
Who can we contact if we cannot reach you?	Name (First, Middle, Last): _____ Street Address: _____ City, State, Zip Code: _____ Telephone Number: _____ Home _____ Work _____ Cell _____ Email: _____				
What company or employer do you believe discriminated against you?	Company Name: _____ Street Address: _____ City, State, Zip Code: _____ Telephone Number: _____ Give the date(s) and times you believe you were discriminated against: _____				
Why do you believe this company or employer discriminated against you?	<table style="width: 100%; border: none;"> <tr> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Race <input type="checkbox"/> American Indian or Alaska Native Indicate Tribal Affiliation: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> National Origin <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other <input type="checkbox"/> Color <input type="checkbox"/> Religion </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Sex/Gender <input type="checkbox"/> Pregnancy <input type="checkbox"/> Retaliation <input type="checkbox"/> Filing a complaint <input type="checkbox"/> Other </td> <td style="width: 25%; vertical-align: top;"> <input type="checkbox"/> Protected Veteran Status <small>(See instructions for definitions) Note: You will be asked to provide a DD Form 214.</small> <input type="checkbox"/> Disability </td> </tr> </table>	<input type="checkbox"/> Race <input type="checkbox"/> American Indian or Alaska Native Indicate Tribal Affiliation: _____ <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	<input type="checkbox"/> National Origin <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other <input type="checkbox"/> Color <input type="checkbox"/> Religion	<input type="checkbox"/> Sex/Gender <input type="checkbox"/> Pregnancy <input type="checkbox"/> Retaliation <input type="checkbox"/> Filing a complaint <input type="checkbox"/> Other	<input type="checkbox"/> Protected Veteran Status <small>(See instructions for definitions) Note: You will be asked to provide a DD Form 214.</small> <input type="checkbox"/> Disability
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Where did you learn you could file a complaint with OFCCP? <input type="checkbox"/> Internet <input type="checkbox"/> Poster <input type="checkbox"/> Community Organization <input type="checkbox"/> OFCCP Meeting/Event <input type="checkbox"/> Brochure <input type="checkbox"/> Other					

Your Complaint:

Please describe below what you believe the employer did or didn't do that you believe caused discrimination or retaliation.

Provide the information below and describe in detail what happened:

- Why you believe the act(s) were (1) discriminatory based on your race, sex, color, religion, national origin, disability, veteran status; and/or (2) retaliation for filing a complaint, participating in discrimination proceedings or otherwise opposing discrimination under any of the above listed bases;
- When did it happen, where and who was involved;
- What harm, if any, was caused to you or others with whom you work as a result of the alleged discriminatory or retaliatory act(s);
- What explanation, if any, was offered for the act(s) by the employer or their representatives; and
- What information do you have on federal contracts held by the company.

Please attach additional pages, if needed.

<p>Do you think the discrimination includes or affects others?</p>	<p>Do you believe other employees or applicants were treated the same way as you described above? _____ Yes _____ No</p> <p>Do you believe there were other employees or applicants who received better treatment than you did because of their race, sex, color, religion, or national origin? _____ Yes _____ No</p>
<p>Do you have an attorney or other representative?</p>	<p>If you are represented by an attorney, or another person, or an organization, please provide their contact information below.</p> <p>Name (First, Middle, Last): _____</p> <p>Street Address: _____</p> <p>City, State, Zip Code: _____</p> <p>Telephone Number: _____ Email: _____</p> <p>Who should we contact if we need more information about your description of what occurred? _____ You _____ Your Representative</p>
<p>Signature and Verification</p>	<p>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.</p> <p>I hereby authorize the release of any medical information needed for this investigation.</p> <p>Signature of Complainant: _____ Date: _____</p>