



**U.S. Department Labor  
Employment and Training Administration**

OMB Approval No. 1205-0039  
Expiration Date: Oct. 31, 2015

For Official Use Only

**Complaint/Apparent Violation Form<sup>1</sup>**

Complaint No.	Date Received	
<b>Part I. Complainant's Information<sup>2</sup></b>		<b>Respondent's Information<sup>3</sup></b>
1. Name of Complainant (Last, First, Middle Initial)		4. Name of Person, Company, or Agency the Complaint is Made Against
2a. Permanent Address (No., St., City, State, ZIP Code)		5. Name of Employer (if different from Part I #4 above) /One-Stop Office
b. Temporary Address (if Appropriate)		6. Address of Employer/One-Stop Office
3a. Permanent Telephone (   ) -	b. Temporary Telephone (   ) -	7. Telephone Number of Employer/One-Stop Office (   ) -
8. Description of Complaint or Apparent Violation (If additional space is needed, use separate sheet(s) of paper and attach to this form)		

**Certification** I CERTIFY that the information furnished is true and accurately stated to the best of my knowledge. I AUTHORIZE the disclosure of this information to other 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.

9. Signature of Complainant <sup>4</sup>	10. Date Signed /      /
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<sup>1</sup> For information regarding complaints that are covered through the Employment Service and Employment-Related Law Complaint System see 20 CFR 658 Subpart E.

<sup>2</sup> If the Complaint/Apparent Violation Form is used to submit an Apparent Violation, the name of the Complainant is not necessary and may remain anonymous. Parts 2a and 2b also do not need to be filled out if the form is used for an Apparent Violation.

<sup>3</sup> For definition of "Respondent" see 20 CFR 651.

<sup>4</sup> No signature is required at Part 9 if this form is submitted as an Apparent Violation.



**Part II. For Official Use Only**

<p><b>1. Migrant or Seasonal Farmworker?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>2. Complaint or Apparent Violation?</b>  Complaint <input type="checkbox"/> Apparent Violation <input type="checkbox"/></p> <p><b>3. Type of Complaint or Apparent Violation</b>  ("X" Appropriate Box(es)):</p> <p><input type="checkbox"/> Employment Service Related  <input type="checkbox"/> Job Order No. _____  <input type="checkbox"/> Against Local Employment Service Office  <input type="checkbox"/> Against Employer  <input type="checkbox"/> Alleged Violation of Employment Service Regulations  <input type="checkbox"/> Employment-Related Law</p>	<p><b>4. Issue(s) involved in Complaint or Apparent Violation</b> ("X" Appropriate Box(es)):</p> <p><input type="checkbox"/> Wage Related <input type="checkbox"/> Housing  <input type="checkbox"/> Child Labor <input type="checkbox"/> Pesticides  <input type="checkbox"/> Working Conditions <input type="checkbox"/> Health/Safety  <input type="checkbox"/> Migrant and Seasonal Agricultural Worker Protection Act (MSPA) <input type="checkbox"/> Disability Discrimination  <input type="checkbox"/> Discrimination Other<sup>5</sup> (Specify) _____</p>	<p><b>5. H-2A/Criteria Employer</b>  ("X" Appropriate Box(es)):</p> <p><input type="checkbox"/> U.S./Domestic Worker  <input type="checkbox"/> H-2A Worker  <input type="checkbox"/> Wages  <input type="checkbox"/> Transportation  <input type="checkbox"/> Meals  <input type="checkbox"/> Housing  <input type="checkbox"/> Other _____</p>
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<p><b>6a. Referrals To Other Agencies</b> ("X" Appropriate Box(es))</p> <p><input type="checkbox"/> WHD. U.S. DOL. <input type="checkbox"/> OSHA U.S. D.O.L.  <input type="checkbox"/> EEOC <input type="checkbox"/> Other _____</p>	<p><b>7. Address of Referral Agency</b> (No., St., City, State, ZIP Code and Telephone No.)  _____  _____</p>
<p><b>b. Follow-Up</b> <input type="checkbox"/> Monthly <b>c. Next Follow-up Date</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quarterly / /</p>	<p>_____</p>
<p><b>8. Explanation of Complaint/Apparent Violation</b> (If additional space is needed, use separate sheet of paper)</p> <p>_____</p>	

<p><b>9. Actions Taken on Complaint/Apparent Violation</b> (If additional space is needed for multiple actions taken, use a separate paper):</p> <p>Action Taken By: _____ On: _____  (First and Last Name) (Date)</p> <p>Action Taken:  _____</p>	
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<p><b>10. Complaint /Apparent Violation resolved?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", explain.    <b>11. Provided other One-Stop Services?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", explain.</p>	
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<p><b>12a. Name and Title of Person Receiving Complaint</b></p>	<p><b>12b. Office Address</b> (No., St., City, State, ZIP Code)</p>	
<p><b>12c. Phone No.</b>  ( ) -</p>	<p><b>12d. Signature</b></p>	<p><b>12e. Date</b> / /</p>

**Public Burden Statement**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control Number. Obligation to reply is required to obtain or retain benefits (44 USC 5301). Public reporting burden for this collection is estimated to average 8 minutes per response, including the time to review instructions, search existing data sources, gather and maintain the data needed, and complete and review the collection of information. Send comments regarding this burden estimate or any other aspect of this collection, including suggestions for reducing this burden, to the U.S. Department of Labor, Employment and Training Administration, Office of Workforce Investment, Room C-4510, 200 Constitution Avenue, NW, Washington, DC 20210.

<sup>5</sup> For DISCRIMINATION COMPLAINTS ONLY. Persons wishing to file complaints of discrimination may file either with the State Workforce Agency, or with the Directorate of Civil Rights (DCR), U. S. Department of Labor, 200 Constitution Avenue, NW, Room N-4123, Washington, D.C. 20210