



# Complaint Involving Employment Discrimination by a Federal Contractor or Subcontractor

Please read the instructions before completing this form.

OMB: 1250-0002

Expires: X/XX/XXXX

Submit

Reset Form

Print Form

<b>How can we reach you?</b>	Name (First, Middle, Last): _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Telephone Number: _____ Home _____ Work _____ Cell _____ E-mail: _____ Have you filed these allegations of employment discrimination with another federal or local agency? _____ Yes _____ No If yes, provide the agency and date filed: _____ Contact Name: _____ Phone Number: _____				
<b>Who can we contact if we cannot reach you?</b>	Name (First, Middle, Last): _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Telephone Number: _____ Home _____ Work _____ Cell _____ E-mail: _____				
<b>What is the name of the employer that you believe discriminated or retaliated against you?</b>	Company Name: _____ Street Address: _____ City: _____ State: _____ Zip Code: _____ Telephone Number: _____ Give the date(s) and times you believe you were discriminated or retaliated against: _____				
<b>Why do you believe your employer discriminated or retaliated against you?</b>	<table style="width: 100%; border: none;"> <tr> <td style="vertical-align: top; width: 33%;"> <input type="checkbox"/> <b>Race</b>  <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="vertical-align: top; width: 33%;"> <input type="checkbox"/> <b>National Origin</b>  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Other   <input type="checkbox"/> <b>Color</b>   <input type="checkbox"/> <b>Religion</b>   <input type="checkbox"/> <b>Sex</b> </td> <td style="vertical-align: top; width: 33%;"> <input type="checkbox"/> <b>Sexual Orientation</b>   <input type="checkbox"/> <b>Gender Identity</b>   <input type="checkbox"/> <b>Inquiring About Pay</b>   <input type="checkbox"/> <b>Discussing Pay</b>   <input type="checkbox"/> <b>Disclosing Pay</b> </td> </tr> <tr> <td style="vertical-align: top;"> <input type="checkbox"/> <b>Protected Veteran Status</b>   <input type="checkbox"/> <b>Disability</b>   <input type="checkbox"/> <b>Retaliation</b> </td> </tr> </table>	<input type="checkbox"/> <b>Race</b> <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"/> <b>National Origin</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Other  <input type="checkbox"/> <b>Color</b>  <input type="checkbox"/> <b>Religion</b>  <input type="checkbox"/> <b>Sex</b>	<input type="checkbox"/> <b>Sexual Orientation</b>  <input type="checkbox"/> <b>Gender Identity</b>  <input type="checkbox"/> <b>Inquiring About Pay</b>  <input type="checkbox"/> <b>Discussing Pay</b>  <input type="checkbox"/> <b>Disclosing Pay</b>	<input type="checkbox"/> <b>Protected Veteran Status</b>  <input type="checkbox"/> <b>Disability</b>  <input type="checkbox"/> <b>Retaliation</b>
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<input type="checkbox"/> <b>Protected Veteran Status</b>  <input type="checkbox"/> <b>Disability</b>  <input type="checkbox"/> <b>Retaliation</b>					
<b>How did you learn that you could file a complaint with OFCCP?</b> <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 think the employer did or didn't do that you believe caused discrimination or retaliation, including:**

- What actions the employer took against you.
- Why you believe those actions were based on your: race; color; religion; sex; sexual orientation; gender identity; national origin; disability; veteran status; and/or inquiries about, discussions, or disclosures of your pay or the pay of others; and/or in retaliation for filing a complaint, participating in discrimination proceedings, opposing unlawful discrimination, or exercising any other rights protected by OFCCP.
- When the employer actions happened, where they happened, and who was involved.
- What harm, if any, you or others suffered because of the alleged discrimination or retaliation.
- What explanation, if any, your employer or people representing your employer offered for their actions.
- Who was in the same or similar situation as you and how they were treated. Include information such as the race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or protected status of these individuals, if known.
- What information you have about federal contracts the company that you worked for had at the time of the discrimination or retaliation you describe in this complaint.

<p><b>Do you think the discrimination includes or affects others?</b></p>	<p>Do you believe other employees or applicants were treated the same way as you described above? _____ Yes _____ No</p>
<p><b>Do you have an attorney or other representative?</b></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><b>Signature and Verification</b></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>