



EQUAL OPPORTUNITY COMPLAINT FORM

| For Labor Office Use Only | |
|---------------------------|--|
| DCIF Received | Jurisdiction |
| By: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date: _____ | Case # _____ |

This form is to be used for complaints against the Missouri Department of Labor and Industrial Relations (DOLIR) or its employees in the provision of services to the public or for complaints by DOLIR employees concerning DOLIR administration, supervisors, or other employees.

This form is not to be used for filing complaints with the Missouri Commission on Human Rights (MCHR) under the Missouri Human Rights Act (MHRA). For information regarding MCHR and MHRA, visit labor.mo.gov/discrimination.

| COMPLAINT INFORMATION <i>(Please print)</i> | | |
|--|---|---|
| First Name | Last Name | Social Security Number <i>(Voluntary)</i> |
| Address | Home Phone <i>(Include Area Code)</i> | Other Phone <i>(Include Area Code)</i> |
| City | State | Zip Code |
| Email Address | | |
| What is the most convenient time and place for us to contact you about this complaint? <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | | |
| To the best of your recollection on what date(s) did the discrimination take place? | Date of First Occurrence | Date of Most Recent Occurrence |
| Basis of Complaint: Which of the following best describes why you believe you were discriminated against. <i>(Check ALL that apply.)</i> | | |
| <input type="checkbox"/> Race <input type="checkbox"/> Religion <input type="checkbox"/> Reprisal/Retaliation <input type="checkbox"/> Political <input type="checkbox"/> Color <input type="checkbox"/> Disability <input type="checkbox"/> National Origin <input type="checkbox"/> Citizenship <input type="checkbox"/> Age: Date of Birth: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | |
| Explain as briefly and clearly as possible what happened and how you were discriminated against. Indicate who was involved. Be sure to include how other persons were treated differently from you. Also attach any written material pertaining to your case. <i>(Attach separate sheet if needed.)</i> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> | | |
| Do you think the discrimination against you involved: <i>(Check one)</i> <input type="checkbox"/> Your previous employer? OR <input type="checkbox"/> A Labor Department employee providing/not providing you with services or benefits? | | |
| If so, which of the following are involved? | | |
| <input type="checkbox"/> Appeal – Tax <input type="checkbox"/> Appeal – Tax Intercept <input type="checkbox"/> Appeal – Lottery Intercept <input type="checkbox"/> Benefit Payments <input type="checkbox"/> Collecting Overpaid Benefits <input type="checkbox"/> Collections <input type="checkbox"/> Contributions Field Auditors <input type="checkbox"/> Filing a New/Renewed/Weekly Claim <input type="checkbox"/> Investigation/Adjudication of a Work Separation or Job Refusal <input type="checkbox"/> Investigation/Adjudication on Able/Available/Schooling <input type="checkbox"/> Other Investigations/Adjudication | <input type="checkbox"/> Overpaid Benefits <input type="checkbox"/> Reporting Requirements <input type="checkbox"/> Request for Confidential Information <input type="checkbox"/> Request to Reconsider a Denial of Benefits <input type="checkbox"/> Questions Regarding TAA/TRA <input type="checkbox"/> Questions Regarding Self-employment/Employment <input type="checkbox"/> Verification of Social Security Number <input type="checkbox"/> Wage Adjustments in Base Period of Claims <input type="checkbox"/> Waiver of Work Search Requirement if Recall Date <input type="checkbox"/> Other: _____ | <hr/> <hr/> |

What other information (if any) do you think is relevant to our investigation? *(Attach separate sheet, if needed.)*

If this complaint is resolved to your satisfaction, what remedies do you seek? *(Attach separate sheet, if needed.)*

Please list below any persons (witnesses, fellow employees, supervisors, or others) that we may contact for additional information to support or clarify your complaint: *(Attach separate sheet, if needed.)*

| Name | Address | Phone No. (Area Code) |
|------|---------|-----------------------|
| | | |
| | | |
| | | |

Do you have an attorney? Yes No

| | | |
|-----------------|--------------------|-------------------------------------|
| Attorney's Name | Attorney's Address | Attorney's Phone Number (Area Code) |
|-----------------|--------------------|-------------------------------------|

Have you filed a case or complaint with any of the following? U.S. Equal Employment Opportunity Commission
 Missouri Commission on Human Rights
 Civil Rights Division, U.S. Department of Justice
 Civil Rights Center, U.S. Department of Labor

For each item checked at the right, please provide the following information:
(Attach separate sheet if more than one is checked.)

| | | |
|--------|------------|-----------------------|
| Agency | Date Filed | Case or Docket Number |
|--------|------------|-----------------------|

| | |
|-----------------------------|--------------------------|
| Location of Agency or Court | Date of Trial or Hearing |
|-----------------------------|--------------------------|

| | |
|----------------------|----------------|
| Name of Investigator | Status of Case |
|----------------------|----------------|

Comments

Have you been provided with a final decision at the Federal level regarding your complaint? Yes No

(Complaint NOT valid unless signed): Please Note: If you elect to file your complaint with the DOLIR, you must wait until the DOLIR issues a decision or until 90 days have passed, whichever is sooner, before filing with the U.S. Department of Labor, Civil Rights Center (CRC), 200 Constitution Avenue, NW, Room N-4123, Washington DC 20210. If the DOLIR has not provided you with the written decision within 90 days of the filing of the complaint, you need not wait for a decision to be issued, but may file a complaint with the CRC within 30 days of the expiration of the 90-day period. If you are dissatisfied with the resolution of your complaint, you may file a complaint with the CRC. Such complaints must be filed within 30 days of the date you received notice of the resolution.

| | |
|-----------|------|
| Signature | Date |
|-----------|------|

Send completed form to:

Jennifer Terry, Equal Opportunity Officer
 Department of Labor and Industrial Relations
 P.O. Box 510
 Jefferson City, MO 65102-0510
 Phone: 573-751-1339
 Fax: 573-751-3668
 Email: EO@labor.mo.gov

*Missouri Department of Labor and Industrial Relations is an equal opportunity employer/program.
 TDD/TTY: 800-735-2966 Relay Missouri: 711*