

**One Stop Career Center (OSCC) Complaint/
Referral Record****U.S. Department of Labor
Employment and Training Administration**OMB Approval No. 1205-0039
Expiration Date: 09/30/2002

For OSCC Use Only

Complaint No.

Date Received

Part I. Complainant's Information**Respondent's Information**

1. Name of Complainant (Last, First, Middle Initial)		4. Name of Person Complaint Made Against
2a. Permanent Address (No., St., City, State, ZIP Code)		5. Name of Employer/OSCC Office
b. Temporary Address (if Appropriate)		6. Address of Employer/OSCC Office
3a. Permanent Telephone () -	b. Temporary Telephone () -	7. Telephone Number of Employer/OSCC Office () -
8. Description of Complaint (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	10. Social Security Number - -	11. Date Signed / /
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Part II. For OSCC Use Only

1. Migrant or Seasonal Farmworker? ☐ Yes ☐ No	3. If non-WIA-related, does Complaint concern laws enforced by U.S. Employment Standards Administration (Wage and Hour) or OSHA? ☐ Yes ☐ No	5. H-2a/Criteria Employer ☐ U.S./Domestic Worker ☐ H-2a Worker ☐ Wages ☐ Transportation ☐ Meals ☐ Housing ☐ Other _____
2. Type of Complaint ("X" Appropriate Box(es)) ☐ WIA Related Job Order No. _____ ☐ Against Job Service ☐ Against Employer ☐ Alleged Violation of WIA Regulations ☐ Alleged Violation of Employment Law(s) ☐ Non-WIA Related	4. Kind of complaint ("X" Appropriate Box(es)) ☐ Wage Related ☐ Housing ☐ Child Labor ☐ Pesticides ☐ Working Conditions ☐ Health/Safety ☐ Migrant and Season Agricultural Worker Protection Act (MSPA) ☐ Disability Discrimination ☐ Discrimination* ☐ Other (Specify) _____	

6. *For DISCRIMINATION COMPLAINTS ONLY. Persons wishing to file complaints of discrimination may file either with the SWA, or with the Directorate of Civil Rights (DCR), U. S. Department of Labor, 200 Constitution Avenue, NW, Room N-4123, Washington, D.C. 20210.

7a. Referrals To Other Agencies ("X" one) ☐ Wage & Hour ESA/U.S. DOL. ☐ OSHA ☐ Other _____	8. Address of Referral Agency (No., St., City, State, ZIP Code and Telephone No.) _____ () - _____
b. Follow-Up ("X" one) ☐ Monthly ☐ Quarterly ☐ Yes ☐ No	c. Follow-up Date / /

9. Comments (If additional space is needed, use separate sheet of paper) Provide OSCC Services? ☐ Yes ☐ No If "No", explain.

10a. Name and Title of Person Receiving Complaint	11. Office Address (No., St., City, State, ZIP Code)
b. Phone No. () -	12a. Signature b. Date / /

Persons are not required to respond to this collection of information unless it displays a currently valid OMC Control Number. Respondents obligation to reply to these requirements are mandatory as required by 20 CFR 651, 653 and 658. Public reporting burden for this collection of information is estimated to average 8 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, U.S. Employment Service, Room C-4514, Washington, DC 20210 (Paperwork Reduction Project 1205-0039).