U.S. Department Labor
Employment and Training Administration

OMB Approval No. 1205-0039
Expiration Date: Dec. 31, 2018

One Stop Career Center (OSCC) Complaint/Referral Record

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. Date Signed	
	/ /	

Part II. For OSCC Use Only

1. Migrant or Seasonal Farmworker?
☐ Yes ☐ No

2. Type of Complaint ("X" Appropriate Box(es))

☐ Job Service Related Job Order No. ___
- ☐ Against Job Service
- ☐ Against Employer
- ☐ Alleged Violation of WIA Regulations
- ☐ Alleged Violation of Employment Law(s)

☐ Non-Job Service Related

3. If non-Job Service-related, does Complaint concern laws enforced by Wage and Hour Division (formerly called the Employment Standards Administration) U.S. D.O.L.
WHD or OSHA? ☐ Yes ☐ No

4. Kind of complaint ("X" Appropriate Box(es))
- ☐ Wage Related
- ☐ Child Labor
- ☐ Working Conditions
- ☐ Migrant and Seasonal Agricultural Worker Protection Act (MSPA)
- ☐ Housing
- ☐ Pesticides
- ☐ Health/Safety
- ☐ Disability Discrimination
- ☐ Discrimination*
- ☐ Other (Specify) _____

5. H-2a/Criteria Employer
- ☐ U.S./Domestic Worker
- ☐ H-2a Worker
- ☐ Wages
- ☐ Transportation
- ☐ Meals
- ☐ Housing
- ☐ Other _____

6. *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.

7a. Referrals To Other Agencies ("X" one)
☐ WHD. U.S. DOL. ☐ OSHA U.S. D.O.L.
☐ Other _____

b. Follow-Up ("X" one) ☐ Yes ☐ No ☐ Monthly ☐ Quarterly

c. Follow-up Date __/__/____

8. Address of Referral Agency (No., St., City, State, ZIP Code and Telephone No.)

_____

_____

(___)___-____

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

Complaint resolved? ☐ 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 / /

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.