NCDOL
N.C. Department of Labor

FOR NCDOL USE ONLY
FILE #

EMPLOYMENT DISCRIMINATION COMPLAINT FORM

INSTRUCTIONS: USE BLACK INK OR TYPE. SIGN AND DATE THE FORM. RETURN THE COMPLETED FORM BY MAIL TO:

NC DEPARTMENT OF LABOR, EDB, 1101 MAIL SERVICE CENTER, RALEIGH, NORTH CAROLINA 27699-1101.

IF SENT BY FACSIMILE [FAX] TO (919) 807-2824, THE ORIGINAL SIGNED FORM MUST BE RECEIVED WITHIN TEN (10) DAYS.

NEED HELP OR HAVE QUESTIONS ? - CALL (919) 807-2823 OR (800) 625-2267 - ASK FOR THE INFORMATION OFFICER.

PERSON MAKING THIS COMPLAINT: (COMPLAINANT)

IF YOUR ADDRESS OR TELEPHONE NUMBER CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY THIS OFFICE.
IF YOU CAN NOT BE CONTACTED, THIS COMPLAINT WILL BE DISMISSED.

1 FULL NAME
Mr. / Mrs. / Ms. _____
Last First Middle Initial

2 ADDRESS:
_____
Street Number Apt. No. Street Name
_____
City State Zip Code County

3 TELEPHONE NUMBER(S) AND E-MAIL ADDRESS:

HOME PHONE	WORK PHONE	OTHER / CELL PHONE
(_____)_____	(_____)_____	(_____)_____
Best time to call: _____ a.m. _____ p.m.	Contact you at work? ☐ YES ☐ NO	Whose number is this?
E-MAIL ADDRESS:		

THIS COMPLAINT IS BEING MADE AGAINST: (RESPONDENT)

NOTE: THE PERSON OR BUSINESS NAMED BELOW WILL RECEIVE A COPY OF THIS FORM.

4a NAME OF BUSINESS OR PERSON (ONLY ONE NAME PER FORM):

5 Estimated Number of Employees:

4b ADDRESS WHERE DISCRIMINATION OR RETALIATION OCCURRED:
_____
Street Number Street Name
_____
City State Zip Code County

6 NAME AND TITLE OF HUMAN RESOURCE or MANAGEMENT OFFICIAL

7 TELEPHONE NUMBER
( )

8 ADDRESS OF HUMAN RESOURCE or MANAGEMENT OFFICIAL [IF DIFFERENT THAN THE ADDRESS IN # 4b, ABOVE]
_____
Street Number Street Name
_____
City State Zip Code

9 TYPE OF BUSINESS/COMPANY (Example: Factory, Mill, Department Store, Restaurant, Etc.)

10 IDENTIFY PRINCIPAL PRODUCT OR SERVICE AT YOUR WORK LOCATION (What Does The Employer Make Or Do?):

EMPLOYMENT DISCRIMINATION COMPLAINT FORM

NOTE: PLEASE FOLLOW INSTRUCTIONS ON THE BACK OF THE LETTER ACCOMPANYING THIS FORM. PROVIDE ONLY BRIEF RESPONSES TO THE QUESTIONS BELOW. IF MORE INFORMATION IS REQUIRED, YOU WILL BE CONTACTED.

11 a WHAT EMPLOYMENT ACTION WAS TAKEN AGAINST YOU BY YOUR EMPLOYER ?
(EXAMPLES: *"I WAS FIRED."*; OR *"I WAS DEMOTED."*; OR *"MY PAY WAS REDUCED."*; OR *"MY SHIFT WAS CHANGED."*)

11 b WHAT WAS THE EXACT DATE OF THE DISCRIMINATION OR RETALIATORY EMPLOYMENT ACTION TAKEN AGAINST YOU ?

_____/_____/_____ THIS COMPLAINT FORM MUST BE RECEIVED BY THE DEPARTMENT OF LABOR NO LATER THAN 180 DAYS FROM THE DATE IN THIS BLOCK.
MONTH DAY YEAR

12 WHY DO YOU THINK YOUR EMPLOYER TOOK THIS EMPLOYMENT ACTION AGAINST YOU?
(GIVE A SHORT STATEMENT SUCH AS: *"BECAUSE I ASKED ABOUT OR FILED A WORKERS' COMPENSATION CLAIM."*; OR *"BECAUSE I COMPLAINED OR FILED A COMPLAINT ABOUT MY WAGES."*; OR *"BECAUSE I COMPLAINED OR FILED A COMPLAINT ABOUT A SAFETY OR HEALTH ISSUE". , ETC"*)

_____

_____

13 IF YOUR COMPLAINT INVOLVES AN INJURY OR ILLNESS, WAS IT A WORK-RELATED INJURY OR ILLNESS?

☐ NO

☐ YES - IF "YES", WHAT DATE DID YOU BECOME ILL OR GET INJURED? _____/_____/_____
Month Day Year

14 IF YOU WERE FIRED BY YOUR EMPLOYER, HAVE YOU STARTED ANOTHER JOB ?

☐ N/A - I WAS NOT FIRED.

☐ NO - I HAVE NOT STARTED A NEW JOB.

☐ YES - IF "YES", ON WHAT DATE DID YOU BEGIN YOUR NEXT JOB? _____/_____/_____
Month Day Year

15 DECLARATION: "THE INFORMATION I HAVE PROVIDED IN THIS COMPLAINT IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF."

NAME (PRINT OR TYPE): _____

SIGNATURE & DATE (REQUIRED): _____/_____/_____
Month Day Year

COMPLAINT FORMS RECEIVED WITHOUT A SIGNATURE AND DATE WILL NOT BE PROCESSED

16 MEDICAL RELEASE (for WORKERS' COMPENSATION related complaints ONLY):

"I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS THAT THE NCDOL DEEMS NECESSARY TO INVESTIGATE MY COMPLAINT. A COPY OF THIS RELEASE SHALL SERVE AS AN ORIGINAL."

NAME (PRINT OR TYPE):_____ DATE OF BIRTH _____/_____/_____
Month Day Year

SIGNATURE & DATE (REQUIRED)_____ DATE _____/_____/_____
Month Day Year

MEDICAL RELEASE RECEIVED WITHOUT A SIGNATURE OR DATES MAY DELAY THE INVESTIGATION.