



Missouri Division of Workforce Development is an equal opportunity employer/program.
 Auxiliary aids and services are available upon request to individuals with disabilities.
 Missouri TTY Users can call (800) 735-2966 or dial 7-1-1.

Missouri Department of Economic Development
 Missouri Division of Workforce Development

DISCRIMINATION COMPLAINT INFORMATION

FOR DWD OFFICE USE ONLY	
DCIF Received:	
By: _____	<input type="checkbox"/> Accepted
Date: _____	<input type="checkbox"/> Not Accepted

Complainant Information (please print)

FIRST NAME		LAST NAME		SOCIAL SECURITY NUMBER (voluntary/optional)	
HOME STREET ADDRESS			HOME TELEPHONE NUMBER (include Area Code)		WORK TELEPHONE NUMBER (include Area Code)
CITY	STATE	ZIP CODE	EMAIL ADDRESS (if available)		

Respondent Information (please print)

NAME of AGENCY				TELEPHONE NUMBER (include Area Code)	
STREET ADDRESS OF AGENCY				FAX NUMBER (include Area Code)	
CITY	STATE	ZIP CODE	EMAIL ADDRESS (if available)		

Complaint Specifics (please print)

What is the most convenient place and time for us to contact you about this complaint?
 Place: _____ Date: _____ Time: _____ AM PM

To the best of your recollection, on what dates did the discrimination take place?
 Date of first occurrence: _____ Date of most-recent occurrence: _____

Have you ever tried to resolve this complaint at the Federal level?
(for example, the U.S. Department of Labor Civil Rights Center; the U.S. Department of Health and Human Services; or the U.S. Department of Agriculture) Yes No
 If "Yes," have you been provided with a final decision at the Federal level regarding your complaint? Yes No

Explain as briefly and as 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 additional written material pertaining to your case to this form.)

EXPANDABLE

To the best of your knowledge, which of the following Missouri One-Stop System programs or services were involved? (Check one)

Adult Programs Dislocated Worker Program

Workforce Investment Act (WIA) Youth Programs Other: _____

Basis of Complaint: Which of the following best describes why you believe you were discriminated against? (Check **all** that apply)

<input type="checkbox"/> Age Specify (Date of Birth): _____	<input type="checkbox"/> National Origin Specify: _____
<input type="checkbox"/> Citizenship Specify: _____	<input type="checkbox"/> Political Affiliation Specify: _____
<input type="checkbox"/> Color Specify: _____	<input type="checkbox"/> Race Specify: _____
<input type="checkbox"/> Disability Specify: _____	<input type="checkbox"/> Religion Specify: _____
<input type="checkbox"/> Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Reprisal/Retaliation Specify: _____
<input type="checkbox"/> Other Specify: _____	

Do you think the discrimination against you involved: (Check one)

Your job, or seeking employment? **OR** Your using facilities or someone providing you with services or benefits?

If so, which of the following are involved? (Check all that apply)

<input type="checkbox"/> Access/Accommodation	<input type="checkbox"/> Enrollment	<input type="checkbox"/> Intimidation/Reprisal	<input type="checkbox"/> Promotion	<input type="checkbox"/> Training
<input type="checkbox"/> Application	<input type="checkbox"/> Exclusion	<input type="checkbox"/> Job Classification	<input type="checkbox"/> Qualification Testing	<input type="checkbox"/> Transfer
<input type="checkbox"/> Benefits	<input type="checkbox"/> Grievance Procedure	<input type="checkbox"/> Layoff/Furlough	<input type="checkbox"/> Recall (from Layoff/Furlough)	<input type="checkbox"/> Transition
<input type="checkbox"/> Discharge/Termination	<input type="checkbox"/> Harassment	<input type="checkbox"/> Performance Appraisal	<input type="checkbox"/> Referral	<input type="checkbox"/> Union Activity
<input type="checkbox"/> Discipline/Reprimand	<input type="checkbox"/> Hiring	<input type="checkbox"/> Placement	<input type="checkbox"/> Seniority	<input type="checkbox"/> Union Representation
<input type="checkbox"/> Other (specify): _____				

What other information do you think is relevant to our investigation? THIS BOX WILL EXPAND TO PROVIDE ADDITIONAL SPACE

If this complaint is resolved to your satisfaction, what remedy do you seek? THIS BOX WILL EXPAND TO PROVIDE ADDITIONAL SPACE

Please list below any persons (witnesses, fellow employees, supervisors, or others) that we may contact for additional information to support or clarify your complaint:

NAME	ADDRESS	TELEPHONE NUMBER (include Area Code)

Do you have an attorney? Yes No If "Yes," please provide attorney's name, address, and phone number below:

ATTORNEY NAME	ATTORNEY ADDRESS	ATTORNEY TELEPHONE NUMBER (include Area Code)
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Have you filed a case or complaint with any of the following? (check all that apply)

Missouri Commission on Human Rights Civil Rights Division, U.S. Department of Justice
 Federal or State Court U.S. Equal Employment Opportunity Commission

For each item checked above, please provide the information below:

AGENCY	DATE FILED	CASE OR DOCKET NUMBER
LOCATION OF AGENCY OR COURT		DATE OF TRIAL OR HEARING
NAME OF INVESTIGATOR	STATUS OF CASE	
COMMENTS THIS BOX WILL EXPAND TO PROVIDE ADDITIONAL SPACE		

AGENCY	DATE FILED	CASE OR DOCKET NUMBER
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This complaint is not valid unless signed and dated. Please note: Filing a discrimination complaint with the Division of Workforce Development does not protect your legal rights regarding other employment discrimination laws. You may file a separate discrimination complaint with the Missouri Commission on Human Rights (MCHR) at (573) 751-3325, or online at http://labor.mo.gov/mohumanrights/File_Complaint/. Complaints filed with DWD, or complaints filed under the Missouri Human Rights Act with the MCHR, must be filed within 180 days from the date of the alleged violation.

SIGNATURE	DATE
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CONSENT FORM

I have filed a Division of Workforce Development (DWD) Discrimination Complaint and understand and agree to the following terms and conditions regarding resolution and investigation of my complaint:

- a) In the course of investigating my complaint, DWD may have to reveal my identity to staff of the program named in my complaint to obtain facts and evidence regarding my complaint;
- b) I may request and receive a copy of any of my own personal information DWD keeps in my complaint file for investigatory uses, and;
- c) Under certain conditions, DWD may be required by the Missouri Sunshine Law, Chapter 610, to reveal to others personal information I have provided in connection with my complaint.

<input type="checkbox"/> Yes, DWD may disclose my identity if necessary to investigate my complaint.	
NAME (please print in full)	
SIGNATURE	DATE

<input type="checkbox"/> No, DWD may <i>not</i> disclose my identity, even if necessary to process my complaint. I do not consent for DWD to disclose my identity during investigation of my complaint. I request that DWD process my complaint; however, I understand that DWD may close my complaint if it cannot begin an investigation because I have not consented for DWD to reveal my identity.	
NAME (please print in full)	
SIGNATURE	DATE

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