

Program Complaint/Apparent Violation Form

Complainant's Information

Last Name	First Name	MI
Address (No., St., City, State, Zip)		
Email		
Phone #	Alt. Phone #	

Respondent's Information

Name of Person Complaint is Against	
Name of Organization/Office	
Address (No., St., City, State, Zip)	
Phone #	Email

Description of the Complaint or Apparent Violation (Please explain the incident and circumstances)

Date of Incident

Desired Resolution (Please explain any resolution(s) you are seeking in response to this complaint)

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.

Can we share this complaint/information with the individual this complaint has been filed against? Yes No

Signature of Complainant (not required for Apparent Violations):
X

Date:

Staff Use Only

What program was involved in the alleged incident? (check all that apply)

<input type="checkbox"/> Employment Service <input type="checkbox"/> Against ESD <input type="checkbox"/> Against Employer <input type="checkbox"/> Alleged Violation of Wagner-Peyser Regulations <input type="checkbox"/> Migrant or Seasonal Farm Worker (MSFW) <input type="checkbox"/> Employment -Related Law Complaint <input type="checkbox"/> Alleged Violation of Employment – Related Law(s) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Workforce Innovation and Opportunity Act (DW, Adult, Youth) Program <input type="checkbox"/> Trade Adjustment Assistance (TAA) Program <input type="checkbox"/> Other Program/Provider: _____ Note: Discrimination Complaints are documented using the complaint form in WSS Policy 1017, Discrimination Complaint Processing. Forward to EO Officer after logging.
--	---

Referrals (if applicable):

Agency/Organization Receiving Referral
 Dept. of Labor & Industries Dept. of Health Human Rights Commission Other: _____

Agency Contact _____ **Phone #** _____ **Email** _____

Actions taken on Complaint/Apparent Violation (use separate paper if additional space needed)

Action taken by: (first and last name) _____ **On: (date)** _____

Complaint/Apparent Violation resolved at local level? Yes No (If no, explain (use separate paper for additional space))

Provided other services? Yes No (If no, explain (use separate paper for additional space))

Name of Staff Person Receiving Complaint/Apparent Violation

Last Name	First Name	Office Address (No., St., City, State, Zip)	
Staff Signature: X		Phone #	Email
Date:			