



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 is being filed 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	3. If non-Job Service-related, does Complaint concern laws enforced by Wage and Hour Division or OSHA? <input type="checkbox"/> Yes <input type="checkbox"/> No	5. H-2a/Criteria Employer <input type="checkbox"/> U.S./Domestic Worker <input type="checkbox"/> H-2a Worker <input type="checkbox"/> Wages <input type="checkbox"/> Transportation <input type="checkbox"/> Meals <input type="checkbox"/> Housing <input type="checkbox"/> Other _____										
2. Type of Complaint ("X" Appropriate Box(es)) <input type="checkbox"/> Job Service Related Job Order No. _____ <input type="checkbox"/> Against Job Service <input type="checkbox"/> Against Employer <input type="checkbox"/> Alleged Violation of WIA Regulations <input type="checkbox"/> Alleged Violation of Employment Law(s) <input type="checkbox"/> Non-Job Service Related	4. Kind of complaint ("X" Appropriate Box(es)) <table border="0"><tr><td><input type="checkbox"/> Wage Related</td><td><input type="checkbox"/> Housing</td></tr><tr><td><input type="checkbox"/> Child Labor</td><td><input type="checkbox"/> Pesticides</td></tr><tr><td><input type="checkbox"/> Working Conditions</td><td><input type="checkbox"/> Health/Safety</td></tr><tr><td><input type="checkbox"/> Migrant and Season Agricultural Worker Protection Act (MSPA)</td><td><input type="checkbox"/> Disability Discrimination</td></tr><tr><td><input type="checkbox"/> Other (Specify) _____</td><td><input type="checkbox"/> Discrimination*</td></tr></table>	<input type="checkbox"/> Wage Related	<input type="checkbox"/> Housing	<input type="checkbox"/> Child Labor	<input type="checkbox"/> Pesticides	<input type="checkbox"/> Working Conditions	<input type="checkbox"/> Health/Safety	<input type="checkbox"/> Migrant and Season Agricultural Worker Protection Act (MSPA)	<input type="checkbox"/> Disability Discrimination	<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Discrimination*	
<input type="checkbox"/> Wage Related	<input type="checkbox"/> Housing											
<input type="checkbox"/> Child Labor	<input type="checkbox"/> Pesticides											
<input type="checkbox"/> Working Conditions	<input type="checkbox"/> Health/Safety											
<input type="checkbox"/> Migrant and Season Agricultural Worker Protection Act (MSPA)	<input type="checkbox"/> Disability Discrimination											
<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Discrimination*											

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) <input type="checkbox"/> Wage and Hour Division <input type="checkbox"/> OSHA <input type="checkbox"/> Other _____	8. Address of Referral Agency (No., St., City, State, ZIP Code and Telephone No.) _____ _____ () -
b. Follow-Up ("X" one) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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 Number () -	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, Migrant and Seasonal Farmworker Program, Room S4209, 200 Constitution Avenue, NW, Washington, DC 20210.