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| State of Wisconsin  Dept of Workforce Development  Equal Rights Division | **Family and Medical Leave Complaint** | **ERD Case #**  **CR** | For ERD Use Only |
| Authorization for this form is provided under Section 103.10(12)(b), Wisconsin Statutes. Completion of this form is voluntary. However, if you wish to file a family and medical leave complaint with the Equal Rights Division (ERD), you must submit a written document containing the information sought in this form. Personal information you provide may be used for secondary purposes (s. 15.04(1)(m), Wisconsin Statutes)  **Provide all information requested. Type or print in black ink.** | | | | |

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| **1. Complainant Information 2. Respondent Information** | | | | | | | | |
| First Name | Middle Name or Initial | | |  | Name of the business you believe violated the law. Name only one Respondent per form. Do **not** name an individual person. | | | |
| Last Name | | | |
| Street Address | | | | Street Address | | | |
| City | | State | Zip Code | City | | State | Zip Code |
| Home Telephone Number  (   ) -     - | | | | Telephone Number  (   ) - - Ext | | | |
| Work Telephone Number  (   ) -     -      Ext | | | | County where the violation took place | | | |
| **3. Employment Status** | | | | | | | | |
| First date of employment with this employer (mm/dd/yyyy) | | | | | | | | |
| I have worked more than 52 continuous weeks for this employer at one or more of it's locations or departments.  Yes  No | | | | | | | | |
| I have worked at least 1,000 hours for this employer during the last 52 weeks.  Yes  No | | | | | | | | |
| A total of at least 50 people work for this employer at all of its locations.  Yes  No | | | | | | | | |
| **4. Previous Family and Medical Leave Use** | | | | | | | | |
| I have used Family or Medical Leave during the current calendar year.  Yes  No   If Yes, how much leave did you take and for what reason: | | | | | | | | |
|  | | | | | | | | |
| My employer has a poster displayed explaining my rights under the Wisconsin Family and Medical Leave Act  Yes  No | | | | | | | | |
| **5. Present Leave Request.**  I have requested leave for the following reason (check appropriate answer) | | | | | | | | |
| For the birth or adoption of my child (Family Leave) | | | | | | | | |
| To care for a seriously ill child, spouse, parent or parent-in-law (Family Leave) | | | | | | | | |
| Name of individual with serious health condition | | | | | | Individual's relationship to you | | |
| Serious health condition description | | | | | | | | |

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| For my own serious health condition (Medical Leave) | | |
| Serious health condition description | | |
| I requested Family Leave for the birth or adoption of my child or to care for a seriously ill family member  Verbally  In writing on | | |
| Name of individual from whom you requested family leave | Individual's Title | |
| I requested medical leave for my own serious health condition  Verbally  In writing on | | |
| Name of individual from whom you requested family leave | Individual's Title | |
| I did not request Family or Medical Leave because I was unaware of my rights | | |
| Amount of leave requested | | |
| Dates expected to be off work | | |
| **6. Denial of Leave** | | |
| Date I received notice that my leave request was denied | | |
| Reason employer denied leave request | | |
| Date rights were violated | | |
| Reason I believe my rights under the Family and Medical Leave Act were violated | | |
| By my signature below, I certify that I have read the above complaint, and, under penalties of law, I declare that this complaint is true and correct to the best of my knowledge and belief. I understand that this complaint is an open record and may be provided to the employer or others under the provisions of Wisconsin’s Open Records Law. | | |
| Complaint or Complainants Representative Signature | | Date Signed |

**The Department of Workforce Development is an equal opportunity service provider. If you need assistance to access services or material in an alternate format, please contact us.**

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| **EQUAL RIGHTS COMPLAINT PROCESS INFORMATION SHEET** | | | | | | | | | | | | | |
| Please complete and return this sheet with your completed complaint. This information is necessary to process your complaint effectively. | | | | | | | | | | | | | |
| Complainant First Name | | | Complainant Middle Name or Initial | | | | | Complainant Last Name | | | | | |
| Current Date | | | Complainant Date of Birth (requested for identification purposes) mm/dd/yyyy | | | | | | | | | | |
| **Contact Information (Important! The Complainant must notify the Equal Rights Division, if there is a change of address or telephone number. If we are unable to locate the Complainant, the complaint may be dismissed).** | | | | | | | | | | | | | |
| Is there a telephone number where the Complainant can be reached between 7:45 a.m. & 4:30 p.m.?  Yes  No | | | If Yes, provide the area code and telephone number  (   ) -     - | | | | | | | | |
| Please provide the name, address, and telephone number of someone who does not reside with the Complainant but who will know where to reach the Complainant. | | | | | | | | | | | | | |
| Contact Person Name | | | | Relationship to the Complainant | | | | | | | | | |
| Street Address | | | | City | | | State | | | Zip Code | | Telephone Number  (   )-   - | |
| **Employer Information** | | | | | | | | | | | | | |
| Approximate number of employees at all of the employer’s work locations  Less than 50  50-100  101-200  201-500  More than 500 | | | | | | | | | | Type of Business | | | |
| Does another company own the employer?  Yes  No  Not Sure | | | | If Yes, please provide the name of that company | | | | | | | | | |
| **Filing With other Agencies** | | | | | | | | | | | | | |
| Have you filed a complaint in this matter with any other agency?  Yes  No | | | | | If Yes, name of agency | | | | | Date filed with the other agency | | | |
| **Settlement Information** | | | | | | | | | | | | | |
| At this time, what is the Complainant seeking to settle the complaint? | | | | | | | | | | | |
| **Complete this section if the Complainant was or still is employed by the employer** | | | | | | | | | | | | | |
| When was the Complainant hired? | | What was/is the job title? | | | | Is the Complainant still employed by the Respondent?  Yes  No | | | | | | | |
| **Complete this section if the Complainant is no longer employed by the employer** | | | | | | | | | | | | | |
| How did the Complainant’s employment end?  Discharged  Quit  Laid off  Retired  Other | | | | | Date Employment Ended | | | | Pay Rate at End | | | | Hours per Week |
| If the Complainant was not promoted, what was the title of the position applied for? | | | | | | | | | RateofPay | | | | Hours per Week |
| **Statistical Information** | | | | | | | | | | | | | |
| **Complainant Sex:**  Male  Female | | | | | | | | | | | | | |
| **Complainant Race** (check appropriate box or boxes): | | | | | | | | | | | | | |
| American Indian or Alaska Native  Native Hawaiian or Pacific Islander  Black or African American  Asian  White  Other | | | | | | | | | | | | | |
| Mail your completed and signed complaint form to one of the following addresses:  EQUAL RIGHTS DIVISION EQUAL RIGHTS DIVISION  201 E WASHINGTON AVE ROOM A100 819 N 6TH ST  PO BOX 8928 ROOM 723  MADISON WI 53708 MILWAUKEE WI 53203    Telephone: 608-266-6860 Telephone: 414-227-4384  FAX: 608-267-4592 FAX: 414-227-4084 | | | | | | | | | | | | | |