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| State of WisconsinDept of Workforce DevelopmentEqual 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: |
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| 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 |