State of Wisconsin
Department of Workforce Development
Equal Rights Division

| ER Case #: |
| --- |
| CR |
| For ERD Use Only |

# Family and Medical Leave Complaint

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.**

## 1. Complainant Information

| First Name | Middle Initial |
| --- | --- |
| Last Name | |
| Street Address | |

| City | State | Zip Code |
| --- | --- | --- |
| | | |

| Telephone Number |
| --- |
| Email Address |

## 2. Respondent Information

| Name of the business you believe violated the law. Name only one Respondent per form. Do **not** name an individual person. |
| --- |
| Street Address |

| City | State | Zip Code |
| --- | --- | --- |
| | | |

| Telephone Number Ext. |
| --- |
| County where the violation took place<br>Select County |

## 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.<br>☐ Yes ☐ No |
| I have worked at least 1,000 hours for this employer during the last 52 weeks.<br>☐ Yes ☐ No |
| A total of at least 50 people work for this employer at all of its locations.<br>☐ Yes ☐ No |

## 4. Previous Family and Medical Leave Use

| I have used Family or Medical Leave during the current calendar year.<br>☐ 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<br>☐ 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 | |
| ☐ 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<br>☐ 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<br>☐ Verbally ☐ In writing on | |
| Name of individual from whom you requested medical 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. | |
| Complaint or Complainant 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.**

# Equal Rights Complaint Process Information Sheet

Please complete and return this sheet with your complaint. This information is necessary to process your complaint effectively.

| Complainant First Name | Complainant Middle 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.?<br>☐ 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<br>☐ Less than 50 ☐ 50-100 ☐ 101-200 ☐ 201-500 ☐ More than 500 | Type of Business |
|---|---|
| Does another company own the employer?<br>☐ 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?<br>☐ 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?<br>☐ Yes ☐ No |
|---|---|---|
| | | |

**Complete this section if the Complainant is no longer employed by the employer**

| How did the Complainant's employment end?<br>☐ 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? | | Rate of Pay | 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
201 E Washington Ave., Room A400
PO Box 8928
Madison WI 53708

Telephone: (608) 266-6860
Fax: (608) 267-4592

Equal Rights Division
819 N 6th ST
Room 723
Milwaukee WI 53203

Telephone: (414) 227-4384
Fax: (414) 227-4084