

Olympic Consortium Program Complaint Form

Complainant's Information			Respondent's Information	
Last Name	First Name	MI	Name of Person Complaint is Against	
Address (No., St., City, State, Zip)			Name of Organization / Office	
Email			Address (No., St., City, State, Zip)	
Phone #	Alt. Phone #		Phone #	Email
Description of the Complaint (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 Certification 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 <input type="checkbox"/> No <input type="checkbox"/>				
Signature of Complainant: X			Date:	
Staff Use Only				
What program was involved in the alleged incident? (check all that apply)				
<input type="checkbox"/> Employment Service (Wagner Peyser)		<input type="checkbox"/> Workforce Investment Act (DW, Adult, Youth) Program		
<input type="checkbox"/> Against ESD		<input type="checkbox"/> Trade Adjustment Assistance (TAA) Program		
<input type="checkbox"/> Against Employer, Job Order WA# _____		<input type="checkbox"/> Other Program/Provider: _____		
<input type="checkbox"/> Alleged Violation of Wagner Peyser Regulations				
<input type="checkbox"/> Alleged Violation of Employment Law(s)				
<input type="checkbox"/> Non-Employment Service Complaint Against Employer				
<input type="checkbox"/> Alleged Violation of Employment Law(s)				
<input type="checkbox"/> Other: _____				
Referrals (if applicable):				
Agency / Organization Receiving Referral				
Dept. of Labor & Industries <input type="checkbox"/> Dept. of Health <input type="checkbox"/> Human Rights Commission <input type="checkbox"/> Other: _____				
Agency Contact		Phone #	Email	
Name of Staff Person Receiving Complaint				
Last Name	First Name	Office Address (No., St., City, State, Zip)		
Staff Signature: X		Date:	Phone #	Email

FORMA PARA QUEJAS

Información Del Reclamante		Información De La Persona/Organización Demandada	
Apellido	Nombre	Nombre y Apellido De La Persona Demandada	
Dirección (número, calle, ciudad, estado, código postal)		Nombre de la Organización, Negocio, Empresa o Empleador	
Email (correo electrónico)		Dirección (número, calle, ciudad, estado, código postal)	
# De Teléfono	# De Teléfono Alternativo	Teléfono	Email (correo electrónico)

Declaración (Explique qué pasó. Incluya nombres, direcciones, números de teléfono, lugares, testigos, etc.)

Fecha Del Incidente

Solución/Resultado Deseado
 (Por favor explique cualquier solución(es) que está buscando en respuesta a la queja)

Certificación: DECLARO que la información que estoy dando es verdadera y correcta de acuerdo con mi conocimiento. AUTORIZO la divulgación de esta información a otras agencias para la investigación apropiada y el cumplimiento de mi queja. ENTIENDO que mi identidad se mantendrá confidencial tanto como sea posible, en consistencia con las leyes que se aplican y con una determinación justa de mi queja.

Podemos compartir esta queja/ información con el individuo que esta queja ha sido presentada en contra? Sí No

Firma Del Reclamante: X **Fecha:**

****Staff Use Only****

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

<input type="checkbox"/> Employment Service (Wagner Peyser) <input type="checkbox"/> Against ESD <input type="checkbox"/> Against Employer, Job Order WA# _____ <input type="checkbox"/> Alleged Violation of Wagner Peyser Regulations <input type="checkbox"/> Alleged Violation of Employment Law(s)	<input type="checkbox"/> Workforce Investment Act (DW, Adult, Youth) Program <input type="checkbox"/> Trade Adjustment Assistance (TAA) Program <input type="checkbox"/> Other Program/Provider: _____
<input type="checkbox"/> Non Employment Service Complaint Against Employer <input type="checkbox"/> Alleged Violation of Employment Law(s) <input type="checkbox"/> Other: _____	

Referrals (if applicable):

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

Agency Contact Phone # Email

Name of Staff Person Receiving Complaint

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