

## Olympic Consortium Program Complaint Form

### Complainant's Information

Last Name	First Name	MI
Address (No., St., City, State, Zip)		
Email		
Phone #	Alt. Phone #	

### Respondent's Information

Name of Person Complaint is Against	
Name of Organization / Office	
Address (No., St., City, State, Zip)	
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  No

**Signature of Complainant: X** **Date:**

### \*\*Staff Use Only\*\*

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

<input type="checkbox"/> <b>Employment Service (Wagner Peyser)</b> <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"/> <b>Workforce Investment Act (DW, Adult, Youth) Program</b>  <input type="checkbox"/> <b>Trade Adjustment Assistance (TAA) Program</b>  <input type="checkbox"/> <b>Other Program/Provider: _____</b>
<input type="checkbox"/> <b>Non-Employment Service Complaint Against Employer</b> <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)
-----------	------------	---

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"/> <b>Employment Service (Wagner Peyser)</b> <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"/> <b>Workforce Investment Act (DW, Adult, Youth) Program</b>  <input type="checkbox"/> <b>Trade Adjustment Assistance (TAA) Program</b>  <input type="checkbox"/> <b>Other Program/Provider:</b> _____
<input type="checkbox"/> <b>Non Employment Service Complaint Against Employer</b> <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)
-----------	------------	---

Staff Signature: X	Date Received:	Phone #	Email
-----------------------	----------------	---------	-------