

Family and Medical Leave Complaint

ERD
Case #
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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.

1. Complainant Information

First Name	Middle Name or Initial	
Last Name		
Street Address		
City	State	Zip Code
Home Telephone Number () - -		
Work Telephone Number () - - Ext		

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		

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 its locations or departments. <input type="checkbox"/> Yes <input type="checkbox"/> No
I have worked at least 1,000 hours for this employer during the last 52 weeks. <input type="checkbox"/> Yes <input type="checkbox"/> No
A total of at least 50 people work for this employer at all of its locations. <input type="checkbox"/> Yes <input type="checkbox"/> No

4. Previous Family and Medical Leave Use

I have used Family or Medical Leave during the current calendar year. <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No

5. Present Leave Request. I have requested leave for the following reason (check appropriate answer)

<input type="checkbox"/> For the birth or adoption of my child (Family Leave)	
<input type="checkbox"/> 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	

<input type="checkbox"/> 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 <input type="checkbox"/> Verbally <input type="checkbox"/> 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 <input type="checkbox"/> Verbally <input type="checkbox"/> In writing on	
Name of individual from whom you requested family leave	Individual's Title
<input type="checkbox"/> 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
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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 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.? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide the area code and telephone number () - -
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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 <input type="checkbox"/> Less than 50 <input type="checkbox"/> 50-100 <input type="checkbox"/> 101-200 <input type="checkbox"/> 201-500 <input type="checkbox"/> More than 500	Type of Business
Does another company own the employer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, name of agency	Date filed with the other agency
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Settlement Information

At this time, what is the Complainant seeking to settle the complaint?
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Complete this section if the Complainant is no longer employed by the employer

How did the Complainant's employment end? <input type="checkbox"/> Discharged <input type="checkbox"/> Quit <input type="checkbox"/> Laid off <input type="checkbox"/> Retired <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Complainant Race (check appropriate box or boxes):		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Other

Mail your completed and signed complaint form to one of the following addresses:

EQUAL RIGHTS DIVISION
201 E WASHINGTON AVE ROOM A100
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