

B. Employer Information

| | | | |
|--|---|----------------------------|----------|
| Name of Company | | Company Owner/Contact Name | |
| Mailing Address | City | State | Zip Code |
| Address where you worked if different | City | State | Zip Code |
| Company Phone Number | Cell Number | Fax Number | |
| Email address, if known | Type of Company (i.e. construction, restaurant, janitorial) | | |
| Has the company filed for bankruptcy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know | | | |
| Is the company still in business? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know | | | |

C. Type of Leave Requested (check appropriate box for type of complaint)

| |
|--|
| Type of Leave requested: <input type="checkbox"/> Family Care Act (FCA) <input type="checkbox"/> Military Spousal Leave <input type="checkbox"/> Emergency Service Leave (ESL) <input type="checkbox"/> Domestic Violence Leave |
| Alleged Type of violation: <input type="checkbox"/> Leave denied <input type="checkbox"/> Discrimination/Retaliation <input type="checkbox"/> Failure to have required poster <input type="checkbox"/> Violation of confidentiality <input type="checkbox"/> Failure to allow the choice of leave (paid or unpaid) <input type="checkbox"/> Failure to restore to same/equivalent position <input type="checkbox"/> Failure to provide reasonably safety accommodation <input type="checkbox"/> Other: _____ |
| Did you request leave from your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date requested: _____ |
| Dates you took or attempted to take leave: _____ |
| Explain the situation in detail. Attach additional sheets if more room is needed: |

D. Signature

- By submitting this form, I hereby affirm & attest that the following is true and accurate to the best of my knowledge and that my name on this form constitutes my signature.

Signature (Print or Type)

Date