RETALIATORY EMPLOYMENT DISCRIMINATION COMPLAINT FORM

N.C. Gen. Stat. §§ 95-240 *et seq*.

NC Department of Labor
Retaliatory Employment Discrimination Bureau (Bureau)
1101 Mail Service Center
Raleigh, NC 27699-1101
1-800-625-2267 (Option #4)
dol.REDB@labor.nc.gov

COMPLAINT FORM INSTRUCTIONS

- All of the following MUST be present for this Bureau to have statutory jurisdiction to investigate your case:

  1) Your REDA complaint must be filed within 180 days of the last alleged adverse employment action taken against you, or it will be dismissed as untimely.

  2) You must have an employee/employer relationship with the person or business you are filing a complaint against. This Bureau does not have jurisdiction to investigate complaints filed by independent contractors.

  3) You must have engaged in a REDA protected activity.

  4) There must have been a retaliatory action (adverse action) ***because*** you engaged in a REDA protected activity. Retaliatory action is defined in the statute as the discharge, suspension, demotion, retaliatory relocation of an employee, or other adverse employment action taken against an employee in the terms, conditions, privileges, and benefits of employment.

  - *Please note that resignation or constructive discharge have not been recognized as adverse/ retaliatory actions for REDA purposes by NC courts.*

  If all of the above are not present, this Bureau will not have the jurisdiction to investigate your complaint, and it will be screened out. If your complaint is screened out and cannot be filed under the provisions or REDA, you may still have grounds to file an effective civil suit.

- You will be required to complete an addendum.
- You must file a separate complaint for each employer that you allege took adverse action against you.
- You must provide the name of the registered agent and registered address of the employer as listed on the NC Secretary of State's website, www.sosnc.gov. If there is no filing with the SOS office, provide the corporate address of the employer.
- The employer(s) will be provided with a copy of your complaint and addendum. You will be provided with a copy of employer's response to your complaint. Both will be redacted in accordance with state and/or federal law.
- Notify the Bureau immediately of any change in street address, email address or telephone number. Your complaint will be dismissed if this office is unable to contact you or you are unresponsive.
- The Bureau will send most documents and letters to you by email instead of first-class or certified mail. Please promptly notify this office of any change to your contact information or if you prefer NOT to be contacted by email. **If you have a gmail account, please check your spam folder often as we have learned that for some people, email from this office is being routed to spam folders.**
- The Bureau will NOT return submitted documents, evidence, or provide "file stamped" copies.

RETALIATORY EMPLOYMENT DISCRIMINATION COMPLAINT FORM

N.C. Gen. Stat. §§ 95-240 *et seq*.

Instructions: This form is fillable; or type or print, sign and date, and mail it with any attachments to:

NC Department of Labor, Retaliatory Employment Discrimination Bureau
1101 Mail Service Center
Raleigh, NC 27699-1101
1-800-625-2267 (Option #4); dol.REDB@labor.nc.gov
*******THIS COMPLAINT MUST BE FILED WITHIN 180 DAYS OF THE LAST ADVERSE ACTION AGAINST YOU.*******

COMPLAINANT INFORMATION

Your (Complainant's) Name:		Cell:	
Street Address:		Home	
City/State:		Alt:	
Zip:		E-mail:	

Your Job Title and Brief Description of Job Duties at Time of Alleged Retaliation:

Hire Date: Date of birth:

THIS COMPLAINT IS AGAINST THE FOLLOWING EMPLOYER

Legal Name of Your Employer (Business or Individual):

D/B/A Name:

Registered Agent/Address as per Secretary of State Website:

Location Where Retaliation Occurred:

Contact Information of Employer's Human Resources Manager/Primary Contact or HR Office:

Name: Title:

Business Phone: Email Address:

Type of Business and Principal Product or Service at Your Work Location:

Name of Supervisor at the Time of Alleged Retaliation:

Supervisor's Phone: Supervisor's Email:

COMPLAINANT'S ALLEGATIONS OF PROTECTED ACTIVITY

Please check the box(es) of the alleged protected activity(ies) you were engaged in ***prior to*** the retaliation/adverse action:

☐ NC Workers' Compensation Act

☐ NC Wage and Hour Act

☐ Occupational Safety and Health Act of North Carolina

☐ NC Mine Safety and Health Act

☐ Discrimination against any person possessing sickle cell trait or hemoglobin C trait prohibited

☐ National Guard Reemployment Rights

☐ Discrimination against persons based on genetic testing or genetic information prohibited

☐ Pesticide Board

☐ Control of Potential Drug Paraphernalia Products

☐ Authority over Parents of Juveniles Adjudicated Delinquent or Undisciplined

☐ Domestic Violence (*obtaining, attempting to obtain or attending court proceedings under NCGS 50B-5.5, 95-270*)

☐ Workplace Violence Prevention (*obtaining, or attempting to obtain, or attending a court proceeding under NCGS 50C, 95-270)*

Please explain the actions you engaged in under the applicable protected activity(ies) you marked above-----

COMPLAINANT'S ALLEGATIONS OF RETALIATION

Describe the Specific Adverse Action(s) Taken Against You By Your Employer:

What was the Exact Date of the Most Recent Adverse Action Against You:

Why do you think the Employer Took This Action Against You? Please Be Specific:

COMPLAINANT'S DECLARATION, CONSENT TO EMAIL COMMUNICATION, AND SIGNATURE

By signing below, I certify that:

- The information I have provided in this complaint and any addendum submitted is true and accurate to the best of my knowledge.
- I have read and understand the instructions on the cover sheet. I understand that I must submit a complaint with an original or electronic signature.
- I agree to cooperate fully with the Bureau in its investigation of my complaint.
- I consent and agree to receive communication from the Bureau by email sent to the address that I have provided below.
- I consent to the use of my email address in lieu of first-class or certified mail notifications except where REDA, the Administrative Rules, or REDB procedures and policies require notification by certified mail.
- I agree to notify the Bureau promptly if there is any change in my contact information.
- I understand that if the Bureau is unable to reach me or if I fail to respond, my complaint will be dismissed and no further action shall be taken.

_____ _____ _____

Complainant's Name (please print) ***Complainant's Signature*** ***Date Signed***

_____

Email Address

* The original or electronic signed Complaint Form **must** be returned to our office for your complaint to be investigated *

RETURN COMPLETED FORM TO: **N.C. Department of Labor, Employment Discrimination Bureau 1101 Mail Service Center, Raleigh, NC 27699-1101**

File No. _____

ADDENDUM TO COMPLAINT (WC)

(PLEASE PRINT OR TYPE IN BLACK INK ONLY AND INCLUDE ADDITIONAL PAGES AS NEEDED)

Full Name: _____
Home Address: _____
Mailing Address (if different): _____
Telephone number(s): _____

1. Employer: _____
   Date of Hire: _____
   Current Employment Status: _____
   Date of Separation: _____

2. Position/Job Title: _____
   Last Rate of Pay: _____
   Shift Worked: _____
   Average number of hours you worked each week: _____
   Last Supervisor: _____

3. Were/are you a member of a union at your employer's place of business? Yes No
   If "Yes", Was/is there a Collective Bargaining Agreement ("CBA") in place? Yes No Unknown
   If "Yes", Does the CBA contain a provision that requires arbitration of all disputes? Yes No Unknown
   [If "Yes" and you have a copy, please provide to us *only* a copy of this provision.]

4. Do you have a lawyer representing you on your workers' compensation claim? Yes No
   If "Yes", Attorney's Name _____
   Attorney's Telephone No.(___) Attorney's Fax No.(___) _____
   Attorney's Address _____

5. **a.** Were you injured at work? Yes No **b.** On what *date* were you injured? _____

6. How were you injured? _____
   _____
   _____

7. Did anyone else see what happened when you were injured? Yes No
   If "Yes", Fully identify any witnesses (including home telephone number) to your accident/injury:
   _____
   _____

8. Did you tell your employer about your injury? Yes No If "Yes", Answer items "a" & "b" below:

a. Who did you tell and when did you tell them? _____

_____

b. List the name and home telephone number of anyone who witnessed you telling your employer about your on-the-job injury: _____

_____

_____

9. Was an accident report filled out? Yes No I don't know
If "Yes", Who filled out the accident report? _____

10. Did you receive medical treatment for your injury? Yes No
If "Yes", **a.** On what **date** was your first visit to the doctor? _____
b. At what **time** on the above date was your first visit to the doctor? _____ (a.m./p.m.)

11. Did you ask your employer to send you to the doctor? Yes No

12. Did your employer send you to a doctor of their choice? Yes No, I went to my own doctor

13. Regardless of who sent you to the doctor, did you tell the doctor that you were injured at work? Yes No

14. Did the doctor contact your employer to verify this was a workers compensation injury?
Yes No I don't know
If "Yes", Who did the doctor talk to and was treatment approved? _____
_____
If not approved, why do you think your employer did not approve medical treatment? _____
_____
_____

15. Did the doctor fill out any workers' compensation paperwork? Yes No I don't know

16. Did you ask your employer about filing a workers compensation claim for you? Yes No ___
If "Yes", Who did you ask about filing workers compensation?_____

17. Did you personally file a workers compensation claim ("Form 18") for your injury? Yes No
If "Yes", *When* **did you file your claim?** _____
(If "Yes", please send to us a copy of the Form 18.)

18. Did you miss any work as a result of this injury? Yes No
If "Yes", What dates were you out of work? _____
_____
_____
_____
_____
_____
_____

19. Did a doctor ever give you a note(s) authorizing you to stay out of work? Yes No
Do you have a copy of the note(s)? Yes No
(If you have a copy of the note(s), please send us a copy when you return this questionnaire. Also, please identify any doctor who gave you a note to stay out of work.)
Dr's Name Dr's Address Dr's Telephone Number/Fax Number

20. Did your employer get a copy of your doctor's notes? Yes No Some of them
If "Yes" or "Some of them", How did your employer get a copy of your doctor's notes? (For example, you gave it to a supervisor, the doctor mailed it, a co-worker took it.) Explain in detail:

21. If your employer got a copy of **SOME** of your doctor's notes **BUT NOT ALL** of them, why not?

22. Did you miss any work that was **NOT** covered by a doctor's note? Yes No
If "Yes", List the dates you missed and the reason(s) you missed work: _____

23. Did your doctor ever give you a note releasing you to return to work? Yes No
If "Yes", When did you return to work? _____
Do you have a copy of the note(s)? Yes No
(If "Yes", please send us a copy of this note.)

24. When you returned to work, did the doctor place you under any light duty restrictions? Yes No
a. If "Yes", What were the restrictions? _____

b. Did the employer provide you with light duty work that met your restrictions? Yes No
c. If "No", What work did the employer have you do that violated your light duty restrictions? _____

d. Did you do the work requested of you by the employer? Yes No

25. Did your doctor ever release you to return to work on full duty? Yes No
If "Yes", When were you released to return to work on full duty? _____

26. Did you ever actually return to work on full duty? Yes No
If "Yes", When was that? _____ If "No", Why not? _____

_____

_____

27. Did your doctor ever give you any ***permanent*** restriction that prevents you from performing the job you were doing at the time of your on-the-job injury? Yes No
If "Yes", *When* were the restrictions given? _____
(Please provide a copy of any documentation regarding restrictions.)

28. Have you reached Maximum Medical Improvement ("MMI")? Yes No
If "Yes", When? _____
(Please provide a copy of any documentation regarding MMI.)

29. What is the status of your workers compensation claim with the North Carolina Industrial Commission? (For example: granted it, denied it, waiting for a hearing or mediation, under appeal)

_____

_____

30. Are you currently receiving workers compensation payments/benefits? Yes No
If "Yes", On what date did the payments/benefits begin? _____

31. Does the company have an employee handbook or written rules? Yes No I don't know
[If "Yes" and you have a copy, please provide to us *only* a copy of the policy or policies that were used to take disciplinary action against you.]

32. **a. BEFORE** your work-related on-the-job injury, did you ever receive any kind of disciplinary action at work (i.e. warned, counseled, written up, pay reduced) for any reason? Yes No
If "Yes", please list:
Date of Action Kind of Discipline Reason for the Disciplinary Action

_____

_____

_____

_____

b. AFTER your work-related on-the-job injury, did you ever receive any kind of disciplinary action at work (i.e. warned, counseled or written up, pay reduced) for any reason? Yes No
If "Yes", please list:
Date of Action Kind of Discipline Reason for the Disciplinary Action

_____

_____

_____

_____

33. What *adverse employment action* did the employer take against you that you believe is retaliatory or discriminatory in nature (for example: fired me, demoted me, reduced my pay) _____

_____

34. *On what date* did the employer take this adverse employment action against you? _____

_____

35. *How* were you notified of the adverse employment action (in person or by letter)?
If "in person", who notified you of the adverse action? _____

36. Were there any witnesses to you being notified of the adverse employment action?
Yes No N/A(notified by letter)
If "Yes", please provide their names, current address, and telephone number:

_____

_____

_____

37. a. What reason(s) do you think the employer will give us as to why it took an *adverse employment action* against you? _____

_____

_____

_____

b. If you think the employer's reason(s) for the action(s) taken against you is/are not true, please explain:_____

_____

_____

_____

_____

_____

38. a. What reason(s) do you have to make you think your employer took an adverse employment action against you *because of* your on-the-job injury/workers' compensation claim?

_____

_____

_____

_____

b. What evidence do you have to support your claim that the employer took an adverse employment action against you *because of* your on-the-job injury/workers compensation claim?

_____

_____

_____

_____

39. a. After your termination/separation, did you file for unemployment compensation with the

Division of Employment Security of North Carolina? Yes No N/A (not fired)
If "Yes", What was the final outcome of your unemployment claim (For example: benefits granted, benefits denied, under appeal) _____
(Please provide a copy.)

b. If you filed for unemployment, have you received any unemployment payments: Yes No
If "Yes", What dates did payments begin and end and how much did you receive each week?
_____

40. What amount of money in *actual* economic loss (i.e. lost wages) have you suffered as a result of the action taken against you by the employer? Please note, you must be able to *document or prove* any alleged actual economic loss attributable to the action taken against you by the employer. _____
_____
_____
_____
_____
_____

41. If your employment was terminated, are you interested in returning to work for your previous employer? Yes No N/A (not terminated)

42. Have you had any other jobs since your termination? Yes No N/A (not terminated)
a. If "Yes", please give a complete listing of all jobs that you have had since your termination. Be sure to include for each job: your date of employment and separation (if applicable), your rate(s) of pay, and the average number of hours worked per week. _____
_____
_____
_____

b. If "No", Why not?
_____
_____
_____

I hereby affirm that the above answers I have provided are true and accurate to the best of my knowledge and belief. I understand that my answers are necessary to help the Retaliatory Employment Discrimination Bureau of the North Carolina Department of Labor determine whether the employer's action against me may have violated the North Carolina Retaliatory Employment Discrimination Act (REDA). I understand that it is my responsibility to promptly notify the NCDOL at such time(s) as my contact information changes and understand that failure to do so may result in the dismissal of my complaint. I also understand that my employer will be provided with a copy of this Addendum to Complaint.

Signature (required)_____ Date_____