Complaint of Employment Discrimination Involving a Federal Contractor or Subcontractor

For OFCCP use only: Pre-Complaint Inquiry Number:

OMB: 1250-0002
Expires: 01/31/2026

Read the instructions below before completing this form.

Instructions

You can file a complaint with OFCCP if you think you have been discriminated against in employment, or in applying for employment, by a company doing business with the Federal Government because of your disability or status as a protected veteran. You can also file a complaint if you believe the employer harassed, intimidated, threatened, coerced, or discriminated against you for filing a complaint, participating in a complaint investigation or compliance evaluation conducted pursuant to the Section 503 of the Rehabilitation Act of 1973 (Section 503) and Vietnam Era Veterans' Readjustment Assistance Act (VEVRAA) authorities, or for exercising other rights protected by 41 CFR 60-300.69 (https://www.ecfr.gov/current/title-41/subtitle-B/chapter-60/part-60-300/subpart-D/section-60-300.69) and 41 CFR 60-741.69 (https://www.ecfr.gov/current/title-41/subtitle-B/chapter-60/part-60-741/subpart-D/section-60-741.69). You do not need to know with certainty that the employer is a federal contractor or subcontractor to file a complaint. If you have questions or need assistance, contact the OFCCP Help Desk at 1-800-397-6251.

Deadline for filing a complaint

Complaints must be filed with OFCCP within **300 days** of the action(s) taken by the employer that you think was either discrimination or intimidation and interference.

Filling out this form

Print or type the information on the form. If you need more space to describe what happened to you, use a separate piece of paper. Remember to attach the piece of paper to the form. **Your signature is required on the complaint form, and if it is not on the form when you submit it, we will ask you to sign it.** If you have authorized another person to file the complaint on your behalf, your representative's signature is required on the complaint form. If you are filing a complaint of discrimination because of your status as a protected veteran, we will ask you to provide your Certificate of Release or Discharge from Active Duty (also known as DD Form 214).

How and where do I file a complaint?

To file a complaint with OFCCP, complete all sections on this form, unless marked as optional. If you do not know the answer to a question, write “not known.” If a question is not applicable, write “N/A.”

If you are filing online, fill out the fields and click Submit. If you are not filing online, send the completed form to OFCCP by mail, fax, or e-mail. Send the form to the OFCCP regional office that covers the state where the events occurred. You may also file in person at an OFCCP office. A list of regional offices and the states that each office covers can be found on the OFCCP website: (http://www.dol.gov/ofccp/contacts/regkeyp.htm).

By completing this form, you are filing a complaint of employment discrimination asserting that the employer discriminated against you. By law, we are required to notify the employer of the complaint.

Have you submitted a pre-complaint inquiry to OFCCP?

☐ Yes ☐ No **Note:** If you have more than 60 days in which to file a timely complaint, we encourage you to submit a pre-complaint inquiry prior to filing a complaint. OFCCP will review your inquiry to determine whether OFCCP is the right federal agency to handle the matter.

How can we reach you?

Name (First, Middle, Last): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ E-mail: _____

Do you have a representative? (Optional)

If you are represented by an attorney, another person, or an organization, provide their contact information:

Name (First, Middle, Last): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ E-mail: _____

Who should we contact if we need more information? ☐ You ☐ Your Representative

What is the name of the employer that you believe discriminated against you or subjected you to intimidation/interference?

Employer Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Human Resources Contact Name (Optional): _____ E-mail (Optional): _____

Is this the same location where the discrimination occurred? _____ Yes _____ No

If no, where did it occur? _____

Give the dates you believe you were discriminated against or subjected to intimidation/interference

Date(s): _____

On what basis do you believe the employer discriminated against you?

Check all that apply

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☐ Intimidation and Interference (harassment, intimidation, threats, coercion, or discrimination) for engaging in any of the following (indicate specific action below):

- ☐ Filing a disability or protected veteran discrimination complaint
- ☐ Participating in an investigation or compliance evaluation conducted pursuant to the Section 503 or VEVRAA authorities
- ☐ Other action covered by 41 CFR 60-300.69 and 41 CFR 60-741.69. Specify: ____

Have you filed this allegation of employment discrimination with another federal or local agency (e.g., Equal Employment Opportunity Commission or state or local Fair Employment or Human Rights Commission)?

☐ Yes ☐ No ☐ I'm not sure

If yes, which agency? ____________________________ When did you file? ____________________________

Agency Contact Name: ____________________________ Phone Number: ____________________________

E-mail: ____ Case Number (if known): ____________________________

Tell us what happened

Describe below what you think the employer did or didn't do that you believe caused discrimination or intimidation/interference, including:

1. Why you believe those actions were based on your disability or veteran status and/or were intimidation and interference in violation of 41 CFR 60-300.69 and 41 CFR 60-741.69.
2. When (on what dates) the employer actions happened, where they happened, and who was involved.
3. What harm, if any, you or others suffered because of the employer's actions.
4. What explanation, if any, the employer or people representing the employer offered for their actions.
5. Who was in the same or similar situation as you and how they were treated. Include information such as the disability or protected veteran status of these individuals, if known.
6. What information you have about federal contracts the company had at the time of the events you describe in this complaint.

Signature and Verification

I declare under penalty of perjury that the information given above is true and correct to the best of my knowledge or belief. I hereby authorize the release of any medical information needed for this investigation.

Signature: _____ Date: _____

Privacy Act Statement

The collection of information using this form is authorized by the legal authorities OFCCP enforces as well as by Title I of the Americans with Disabilities Act of 1990 (ADA), as amended, which the U.S. Equal Employment Opportunity Commission (EEOC) enforces. OFCCP uses this information to process complaints and conduct investigations of alleged violations of these employment discrimination laws. OFCCP will provide a copy of this complaint to the employer against which it is filed. OFCCP may also refer this complaint to other agencies that may have jurisdiction and provide a copy of the complaint to the referral agency that may have jurisdiction. The information collected may be: 1) verified with others who may have knowledge relevant to the complaint; 2) used in settlement negotiations with the employer or in the course of presenting evidence at a hearing; or 3) disclosed to other agencies with jurisdiction over the complaint.

Providing this information is voluntary; however, failure to provide the information may delay or prevent OFCCP from investigating your complaint and, for matters covered by the ADA, may affect your right to sue under this law.

Public Burden Statement

The estimated time to complete this form is 1 hour, including time for reviewing instructions, filling out the form and sending it to OFCCP. Please note that you are not required to respond to this collection of information unless it displays a currently valid OMB Control Number.

If you have comments regarding the estimated burden or any other aspect of this complaint form, including suggestions for reducing the burden, send them to the OFCCP Policy Division (1250-0002), 200 Constitution Avenue, N.W., Room C3325, Washington, D.C. 20210. **Please do not send the completed complaint form to this address.**